# HEALTH SERVICES AGREEMENT

*January 1, 2009 ~ December 31, 2009*

## STATE OF INDIANA EMPLOYEES

(INCLUDING THE PARTICIPATING LOCAL UNIT OF GOVERNMENT EMPLOYEES)

**Pending IDOI Approval**

WELBORN HEALTH PLANS

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***Management and administrative services are provided to Welborn Health Plans by U.S. Healthcare Holdings, LLC, an insurance administrator licensed by the State of Indiana.***

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# HEALTH SERVICES AGREEMENT

## 1. DEFINITIONS

The words and phrases defined in this Section are listed throughout this Agreement and all Exhibits, Riders and the Member Handbook. The remaining words used in this Agreement have the normal meanings of daily language.

1.1 **Appeal**. A complaint made by a Member who disagrees with a decision on his health care services.

1.2 **Appeals Committee**. Second level complaints will be reviewed and decided upon by a designated physician outside of WHP.

1.3 **Appropriate Care (Appropriateness)**. Health care services and items that are clinically justified. This term is sometimes used interchangeably with Medically Necessary. It is sometimes used to refer to whether the use of a particular site of care (e.g., Hospital), site of treatment, length of treatment, or plan of treatment is justified.

1.4 **Approved Referral**. A communication (oral, written, or electronic) sent by a PCP or other Participating Provider that specifies the health services to be rendered by another Provider identified in such communication and approved by the WHP Health Services Department (HSD) or WHP Medical Director. This approval is not a guarantee that WHP will Cover the requested health service or item because of other provisions in this Agreement. Exhibits, Eligibility, Exclusions, Limitations, Coordination of Benefits, the Benefit Summary and any applicable Riders also control whether a requested health service or item will be Covered by WHP.

1.5 **Benign Skin Lesions**. Any non-malignant skin lesions.

1.6 **COBRA**. The Consolidated Omnibus Budget Reconciliation Act of 1985, as enacted by Public Law 99-272, and may be amended from time to time.

1.7 **Coinsurance**. The percent of Eligible Charges that the Member must pay to a Provider. Required Coinsurance amounts are shown in Exhibit 2 of this Agreement.

1.8 **Complaints**. The formal expression of a grievance concerning, but not limited to, Coverage, Providers or benefits.

1.9 **Copayment or Copay**. A fixed dollar amount that must be paid by a Member to a Provider for Covered Services. Required Copayment amounts are shown in Exhibit 2 of this Agreement.

1.10 **Cosmetic**. Services performed to improve appearance or to correct a disease, defect or condition that does not cause a significant problem in body function.

1.11 **Cover, Covered, Coverage or Covered Services**. The services arranged for, paid for by WHP and for which benefits apply.

1.12 **Custodial, Custodial Care, Residential Care, or Long-Term Care**. Care in an inpatient or outpatient setting to protect or maintain a stable level of functioning in a patient whose general condition and physical findings remain substantially constant, and for which, in the opinion of the Medical Director, no improvement is expected. Such care is Custodial even if the level of maintenance care requires services of some skilled health professionals.

1.13 **Deductible (applies to the Welborn Health Options and Welborn Health Options ~ SELECT products only)**. The amount of Eligible Charges for Covered services that Members must first pay directly to Providers before WHP provides benefits during a calendar year. Deductible amounts, if any, are indicated in Exhibit 2 of this Agreement.

1.14 **Dental Services**. Professional services for the diagnosis and treatment of disease or defects of, or accidental injury to, the teeth, gums, jaws and associated structures. Dental Services include dental examination and consultations, oral surgery and hospitalization for dental-related care.

1.15 **Dependent**. Please refer to Section 2 - Eligibility and Enrollment of this Agreement for definition.

1.16 **Durable Medical Equipment (DME)**. Products that are required for treatment, rehabilitation of, or compensation for medical disability that are primarily medical, non-disposable, and intended for repeated use.

1.17 **Eligible Charge**. The amount of money WHP allows for Covered services. This amount includes what both WHP and the Member are to pay.

1.18 **Eligible Employee**. All Eligible Employees must live and/or work in the WHP Service Area.

1.19 **Emergency or Emergent**. The sudden and unexpected onset of a condition that needs medical care. A Member must receive this care as soon as possible. Some examples of an Emergency would be a heart attack, stroke, poisoning, fainting, trouble breathing and heavy bleeding. These severe conditions must start suddenly and be unexpected. The conditions must be severe enough to cause a prudent layperson to seek medical help immediately. They are conditions that one could reasonably expect to cause serious harm if not given immediate attention. A prudent layperson is one who has an average knowledge of health and medicine and who could reasonably expect serious harm to occur if immediate medical attention is not received.

1.20 **Enrollment Form**. A form provided by WHP to gather specific information about a Subscriber and his Dependents. Where appropriate, the form is to be signed by the Subscriber to show the Subscriber's agreement to accept and comply with the terms of this Agreement.

1.21 **Experimental/Investigative**. A health care service is Experimental/Investigative if WHP's Medical Management staff determines:

A) It is a drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration ("FDA") and FDA approval has not been given at the time the drug or device is proposed to be used; or

B) It is a drug, device, medical treatment, or procedure, for which:
   (1) 21 C.F.R. §50.20 and/or 45 C.F.R. §46.116 require(s) that a patient informed consent document be used; and
   (2) Federal law requires the review and approval of such drug, device, medical treatment or procedure by the treating facility's Institutional Review Board or other body serving a similar function; or

C) It is a drug, device, medical treatment or procedure that reliable evidence shows:
   (1) Is the subject of on-going phase I, phase II or phase III clinical trials;
   (2) Is under study to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness, or its effectiveness compared with a standard means of treatment or diagnosis; or

D) It is a drug, device, medical treatment or procedure needing further studies as shown by reliable evidence that establishes that the current prevailing opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its effectiveness or its effectiveness as compared with the standard means of treatment or diagnosis; or

E) With regard to treatment of the Member's diagnosed condition, disease or injury, reliable evidence has not established the effectiveness of the proposed medical treatment or procedure or the proposed use of the drug or device for that particular condition, disease or injury.

Reliable evidence is published reports and articles in authoritative medical and scientific literature or written protocol(s) or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

1.22 **Grievance Committee**. A committee comprised of five (5) individuals designated by WHP. The Committee is composed of three (3) individual consumers who are Members of WHP and two physicians. The committee will consider, review, and attempt to resolve disputes between WHP and Members.

1.23 **Grievance Procedure**. The process by which a Member or Participating Provider presents a Complaint.

1.24 **Health Care Professional**. Physicians, audiologists, chiropractors, dentists, dieticians, nurse clinicians, optometrists, physical therapists, physicians' assistants, podiatrists, psychologists, social workers, speech therapists and other professionals who perform health services. The Healthcare Professional must also be either licensed or practice under the authority of a licensed Health Care Professional.

1.25 **Health Services Department**. A Department within WHP composed of the following three (3) areas:

A) Utilization Management. Utilization Management is responsible for administering WHP's Medical Management programs, including Referrals, Precertification, Concurrent Review and Discharge Planning.

B) Case Management. Case Management is responsible for assisting and coordinating the care of patients with catastrophic illnesses or injuries. The goal is to enhance the Member's quality of life while encouraging the most cost-effective use of his medical benefits. Members and Physicians are informed of the Member's plan benefits and possible treatment options to give the Members more choices. Needed services are also coordinated to foster Member independence.

C) Quality Improvement. Quality Improvement provides a continuous and efficient monitoring of Provider processes and outcomes. Quality Improvement objectives are put into action and maintained to ensure compliance with State, Federal and other accrediting, licensing, or reviewing agency requirements.

1.26 **HIPAA**. Health Insurance Portability and Accountability Act of 1996.

1.27 **Home Health Care**. Health Care services given in the home that are Medically Necessary and not Custodial in nature. A licensed Health Care Professional who is not related to the Member receiving care shall provide these services. These services shall include, but are not limited to, skilled nursing visits, physical therapy, speech therapy, and/or occupational therapy.

1.28 **Hospice Care**. Services provided to or for the benefit of a Member diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. The term also includes services given in agreement with Medicare-certified programs, under the direction of a Physician.

1.29 **Hospital**. An institution:

A) Constituted, licensed and run according to the laws of the state in which it is located.

B) Has the inpatient facilities needed to diagnose and treat injury and sickness.

C) Provides services under Medicare.

The term "Hospital" will not include an institution that is, other than incidentally, a nursing home or a Federal Hospital.

1.30 **Infertility**. Infertility services are medical/surgical services performed to investigate and treat the causes of Infertility. Causes of Infertility include the inability to conceive (get pregnant) or cause pregnancy, maintain pregnancy until full term, or maintain or improve future desired fertility. Services are limited to: (i) Diagnostic services for the Member or Covered partner(s) to decide cause or reason for infertility; (ii) Pathology and laboratory services; (iii) Surgical services and; (iv) Drugs prescribed for Infertility treatment.

A) To be Covered, all Infertility services must be requested by a PCP and approved by the Medical Director. Covered Services will only be provided for Members. Partners or spouses who are not Members are ineligible for Covered Infertility diagnostic and treatment services. In order to be considered for Covered Services related to the evaluation and treatment of Infertility, a Member must meet the following criteria:

(1) The Member must be married and the Member and the Member's spouse must have had unprotected intercourse without conception for at least one (1) year; and
(2) The male partner must have had a sperm analysis performed:
a) If the male partner is a Member, a Participating Provider must have performed the sperm analysis.
b) If the male partner is not a Member, the results of a sperm analysis must be sent to the Member's PCP.
(3) The female partner must have been unable to achieve and sustain two (2) successful pregnancies in her lifetime.

B) Limitations:
(1) Benefits for Covered Infertility evaluation and treatment services do not extend beyond two (2) years.
(2) If pregnancy is achieved, but is ended through spontaneous abortion or premature birth, Covered Infertility benefits will be extended for a one (1) year period following the fetal loss as long as the Member is still eligible for Coverage under a valid Infertility Rider.
(3) In no circumstances will services for Infertility be Covered beyond two (2) successful pregnancies resulting in living infant birth. These services are Covered only if the current Agreement or Rider covering Infertility is still in force and the Member is still an eligible Member.
(4) Services in Infertility evaluation and treatment will only be Covered as long as the treated person is a Member.

1.30 **Inherited Metabolic Disease**. Defined as:
A) Caused by inborn errors of amino acid, organic acid, or urea cycle metabolism; and
B) Treatable by the dietary restriction of one (1) or more amino acids.

1.31 **Late Enrollee**. Please refer to Section 2.2.4 for definition.

1.32 **Lifetime Benefit Maximum**. The total dollar amount in benefits per Member that will be paid under this Agreement. This amount is not renewable.

1.33 **Limiting Age**. The age when a child of a Subscriber ceases to qualify as a Dependent

1.34 **Maternity Services**. Obstetrical services rendered to a woman from the time the diagnosis of pregnancy is established until delivery or termination of pregnancy and discharge from the hospital or other facility for rehabilitation services.

1.35 **Medical Director**. A Physician designated by WHP to direct its medical affairs.

1.36 **Medical Food**. Defined as:
A) Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
B) Formulated to be consumed or administered enterally under the direction of a Physician.

1.37 **Medical Transportation Services**. The transportation of a sick, injured, infirm, or otherwise disabled person by ambulance or other medical transportation vehicle that is licensed, operated, and equipped in agreement with applicable state or local statues, ordinances, or regulations.

1.38 **Medically Necessary**. A health care service or item that, in the judgment of the Medical Director or his designee:
A) Is appropriate and consistent with the diagnosis and that could not have been omitted without harming the patient's condition or the quality of health services received, as in agreement with accepted medical standards in the WHP Service Area.

B) Is required for reasons other than (i) the convenience of the Member or his Physician or (ii) solely for Custodial Care, comfort, convenience, appearance, educational, recreational, vocational or maintenance reasons.

C) Is performed in the most appropriate manner in terms of treatment method, setting, frequency and intensity, taking into consideration the Member's medical condition and type of setting appropriate for the condition.

D) As to inpatient care or institutional care, could not have been provided in a Physician's office, the outpatient department of a Hospital or a non-residential facility without harming the patient's condition or quality of health services received.

E) Is not excluded by Medicare Guidelines.

1.39 **Member(s)**. A Subscriber or Eligible Dependent for whom WHP has agreed to provide health care services.

1.40 **Member Effective Date**. Date Member becomes eligible under this Agreement as defined in Section 2. – Eligibility and Enrollment.

1.41 **Morbid Obesity**. Defined as:

A) A body mass index (equals weight in kilograms divided by height in meters squared) of at least thirty-five (35) kilograms per meter squared with co morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

B) A body mass index of at least forty (40) kilograms per meter squared without co morbidity.

1.42 **Non-Participating**. A person or institution that does not have a contract or arrangement with WHP to provide Covered Services to Members.

1.43 **Open Enrollment**. The period of time, prior to the Agreement Start Date or Anniversary Date, as designated by the Employer. Subscribers and Dependents are eligible to enroll under this Agreement during Open Enrollment.

1.44 **Orthotic**. Biomechanical devices used to correct diseases or disorders of locomotion.

1.45 **Out-Of-Area**. A location outside of the WHP Service Area. The Subscriber must live or work in the Service Area to be eligible for coverage under this Agreement.

1.46 **Out-Of-Plan**. Covered Services that are not provided by a Member's PCP or obtained by an approved referral from the Member's PCP. For example, seeking care from a Physician who is not a Participating Provider for non-Emergency conditions is Out-Of-Plan. Out-Of-Plan services will not be Covered or paid for unless WHP gives advance authorization (Precertification) to the Member to obtain such services. If Out-Of-Plan services are Precertified by WHP, the Member is responsible for submitting claims to WHP within ninety (90) days and for paying any applicable Copayments, Coinsurance and Deductibles. A Member is responsible for paying all costs of obtaining Out-Of-Plan services that are not Precertified.

1.47 **Out-Of-Pocket Maximum**. The maximum amount of money a Member has to pay during a calendar year for Eligible Charges for Covered Services.

1.48 **Participate(s)(ing)**. A Provider who is under contract with WHP to provide services to Members pursuant to this Agreement.

1.49 **PHI (Protected Health Information)**. Information that contains individually identifiable health information.

1.50 **Physician**. A person who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in the state in which he practices.

1.51 **Plan Sponsor**. The Employer, State of Indiana or Local Units of Government, that has elected to participate by completing a Local Unit Adoption Agreement and Binders.

1.52 **Precertification/Precertified**. The process for obtaining prior approval for a proposed health service.

1.53 **Pre-Existing Condition**. Generally, a pre-existing condition is a physical or mental condition for which a Member has received medical services or care for a defined period of time immediately prior to the Member's effective date of Coverage under this Agreement. WHP does not limit Pre-existing conditions under this Agreement. However, WHP does exclude specific services in this Agreement.

1.54 **Prescription Drugs**. Drugs or medications, the sale or dispensing of which, legally requires the order of a Physician or a Provider and that carry the Federally required product legend stipulation that such drug may not be dispensed without a prescription. Prescription Drugs must be dispensed by a Participating pharmacy.

1.55 **Primary Care Physician (PCP)**. A pediatrician, family practice Physician, or internal medicine Physician who is a Participating Provider. This Physician is selected by the Member and named by WHP to manage all of the Member's health needs.

1.56 **Prosthetic**. Devices that are prescribed to replace all or part of an absent body part or to replace all or part of the function of a permanently inoperable or malfunctioning body part.

1.57 **Provider**. A Health Care Professional, licensed health care institution (a Hospital, Skilled Nursing Facility, or Rehabilitation Facility), or a supplier.

1.58 **Reconstructive**. Services required to correct a significant defect in bodily function caused by a birth defect or an injury/disease.

1.59 **Referral or Referred**. A communication sent by a PCP or other Participating Provider (oral, written, or electronic) that specifies health services to be rendered by another Provider identified in such communication.

1.60 **Rehabilitation Facility**. A facility providing complex medical or behavioral treatment and skilled nursing services intended to restore an individual to a maximum level of functioning following a disabling disease or injury.

1.61 **Residential Treatment Facility**. A Provider constituted, licensed and operated as set forth in applicable state law. Examples include, but are not limited to:

A) A facility providing inpatient care and/or treatment for persons who are being treated for mental health, chemical and/or alcohol dependency, eating disorders, or behavioral disorders.

B) A rest, educational, or custodial Provider or similar place.

1.62 **Rider**. An optional benefit that the Member's Employer may elect to include as Covered Services

1.63 **Selected Benign Skin Lesions**. Defined as: Lipomas, Sebaceous cysts, Viral warts, Mulluscum, and inflamed seborrheic keratoses.

1.64 **Semi-Private**. A room in a Hospital, Skilled Nursing Facility or any other inpatient facility containing two (2) or more beds and/or classified as Semi-Private by such facility.

1.65 **Service Area**. The counties and states where WHP provides or arranges for the health care services to WHP Members. The Subscriber must live or work in the Service Area to be eligible for coverage under this Agreement.

WHP's Service Area includes the counties listed in Exhibit 1 of this Agreement. All other locations are outside the Service Area or "Out-of-Area."

1.66 **Skilled Nursing Facility**. A facility that:

A) Is primarily engaged in providing skilled nursing care and related services on a twenty-four (24) hour a day basis to inpatients requiring medical or skilled nursing care.

B) Is recognized and eligible to be paid under Medicare as a Skilled Nursing Facility.

1.67 **Subscriber**. An employee of the Employer who is either:

A) Eligible under the Employer's medical benefit plan.

B) Eligible under other established standards of the Employer and WHP who lives or works in WHP's Service Area and who has enrolled in WHP.

1.68 **Urgent or Urgent Condition**. An acute health problem that starts suddenly and is not expected. It is not a threat to life, but has a serious danger to health if not treated within twenty-four (24) hours. Examples of Urgent Conditions can be simple fractures, cuts needing stitches and serious infections.

## 2. ELIGIBILITY AND ENROLLMENT

2.1 **Eligibility, Enrollment and Effective Date.**

A) Eligibility

(1) All active full-time (37.5 hours per week) employees and their eligible "Dependents".

(2) All appointed or elected officials and their eligible "Dependents".

(3) Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.

(4) "Dependent" means:

a) Spouse of an employee;

b) Any unmarried Dependent children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee's home for whom the employee or spouse has been appointed legal guardian, under the age of 19 (or 23 if the child is a full-time student at an educational institution). Such child shall remain a "Dependent" until marriage or the end of the calendar year in which he/she attains age 19/23. In the event a child who is a "Dependent" as defined herein, is both:

(i.) Incapable of self-sustaining employment by reason of mental or physical disability, and

(ii.) Is chiefly Dependent upon the employee for support and maintenance; such child's coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the end of the calendar year in which the maximum age is attained. Coverage for the "Dependent" will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment.. Proof of disability and prior coverage will be required. The plan requires annual documentation from a physician after the child's attainment of the limiting age.

(iii.) Children between the ages of 19 and 24 (when extension of coverage is requested as allowed by IC 27-13-7-3(a)(26)) who are biological or adopted children of the employee regardless of support level, step-children, children for whom the employee has been appointed legal guardian, grandchildren, or blood relatives who depend on the employee for more than 50% of the individual's total support.

(5) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Legislator", dependent or spouse as defined and pursuant to the conditions set forth in IC 5-10-8..

(6) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

a) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

b) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;

c) Must have fifteen (15) years of participating in a retirement fund.

(7) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

a) Must have retired after December 31, 2006.

b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

c) Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;

(8) "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:
   a) Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
   b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
   c) Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

(9) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:
   a) Retirement date is after June 30, 1990;
   b) Will have reached the age of sixty-two (62) on or before retirement date;
   c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
   d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

(10) A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
   a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;
   b) Whose retirement date is after January 1, 1990;
   c) Who is at least sixty-two (62) years of age;
   d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
   e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

(11) Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility end on the earliest of the following:
   a) Twenty-four (24) months from the date the deceased Retiree's coverage is terminated. At the end of the period the spouse would be eligible to remain covered until the end of the maximum period under COBRA;
   b) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
   c) The end of the month following remarriage; or
   d) As otherwise provided by Act of the General Assembly.

(12) Employee on a leave of absence for ninety (90) days or less and out of pay status.

(13) An employee on family leave.

(14) Retirees eligible under IC 5-10-12.

(15) All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
   a) A city, town, county, township, public library, municipal corporation or school corporation;
   b) Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.

(16) As otherwise provided by Act of the Indiana General Assembly.

B) Enrollment

*State of Indiana Employees*

(1) New employees are given to the Monday following the end of the payroll period of their date of hire to enroll.

(2) Elected officials and legislators must enroll by January 31st of the year following election or re-election.

(3) Dependents born or acquired after the date of enrollment must be added within thirty (30) days of the marriage, birth, etc.

(4) Enrollment or changes not in accordance with paragraph 1, 2 or 3 may be made as follows:
   a) During open enrollment period(s) designated by the State;
   b) Based on the interim qualifying events under Section 125 of the Internal Revenue Code;
   c) Or for correction of errors.

(5) Persons who have elected coverage hereunder and who have a payroll relationship to the State Auditor must authorize payroll deductions to pay their portion of the cost. Certain disabilitants, certain employees on leave without pay, retirees, local units of government and direct bill agencies remit fees directly to the Vendor.

(6) All eligibles, disabilitants and their Dependents must be allowed to enroll during open enrollment without regard to an active work requirement or pre-existing condition(s).

*Local Unit of Government*

(1) New employees are given to the Monday following the end of the payroll period of their date of hire to enroll, unless otherwise modified by the Local Unit's Binder.

(2) Elected officials must enroll by January 31st of the year following election or reelection, unless otherwise modified by the Local Unit's binder.

(3) Dependents born or acquired after the date of enrollment must be added within thirty (30) days of the marriage, birth, etc.

(4) Enrollment or changes not in accordance with paragraph 1, 2 or 3 may be made as follows:
   a) During open enrollment period(s) designated by the State;
   b) Based on the interim qualifying events under Section 125 of the Internal Revenue Code;

(5) Persons who have elected coverage hereunder and who have a payroll relationship to the Local Unit must authorize payroll deductions to pay their portion of the cost. Certain disabilitants, certain employees on leave without pay, Retirees and Local Units remit fees directly to the Vendor.

(6) All eligibles, disabilitants and their Dependents must be allowed to enroll during open enrollment without regard to an active work requirement or pre-existing condition(s).

2.2 **Enrolling in WHP**. Eligible Employees and any Dependents who are eligible may enroll with WHP during an Open Enrollment period. The Eligible Employee or Dependent must complete all steps of the enrollment process.

2.2.1 Selecting a PCP. Members must choose a PCP from the list of Participating PCPs named by WHP. WHP has the right to change its list of Participating PCPs at any time. WHP will choose a PCP for Members who do not make their own selection.

A) Changing Your PCP. Members are allowed to change their PCP up to twice annually. If the Member requests a PCP change through WHP's Member Services Department on or before the fifteenth (15th) of the month, the change of PCP will be effective the first day of the following month. Otherwise, the change will be effective on the first day of the second month following the request. If the Member's PCP ceases to be a Participating PCP, WHP will notify the Member in writing and assist the Member in selecting a new PCP. Members who have already changed their PCP the maximum number of times allowed and wish to express dissatisfaction with their current PCP, may use the Grievance Procedure defined in Section 15.

B) PCP Initiated Changes**.** The PCP has the right to have a Member transferred to another Participating PCP. The PCP must submit the request in writing to WHP with at least thirty (30)

days advance notice. During that time, the PCP must continue to provide or otherwise arrange for medical care for the Member until the Member has been successfully transferred to another Participating PCP. WHP will work with the PCP and the Member to determine the timing of the transfer.

A Member may be transferred to another PCP under the following circumstances as defined by the PCP:

(1) The Member's behavior is disruptive, abusive and/or threatening.
(2) The Member does not comply with the PCP's directions and the PCP believes that a reasonable medical alternative does not exist.
(3) A change in the physical condition of the Member requires services that are not within the specialty of the Physician as jointly determined by WHP and the PCP.
(4) The Member was previously unable to establish a proper patient-Physician relationship.
(5) The Member repeatedly makes but fails to keep appointments for health services.

2.2.2 Initial Open Enrollment Period. Before the initial Agreement Start Date, employees have the chance to enroll themselves and any eligible Dependents.

2.2.3 Enrollment of New Employees. Employees who become eligible or are hired after an Employer's Agreement Start Date may enroll themselves and any eligible Dependents on the date they become eligible.

2.2.4 Special Enrollment Periods. Late Enrollee means an Eligible Employee or the Dependent of an Eligible Employee who did not request enrollment with WHP during the initial Open Enrollment period during which they were first entitled to enroll. A Late Enrollee may enroll within thirty (30) days of a Status Change. The term "Status Change" includes:

A) An Eligible Employee or eligible Dependent who:
   (1) Was Covered under another health insurance plan or had other health insurance coverage at the time coverage was previously offered to them and who states in writing that coverage under another health insurance plan was the reason for declining the enrollment; and
      a) Was under a COBRA continuation provision and the coverage under that provision is now exhausted; or
      b) The Employer offers multiple health insurance plans and the Eligible Employee or their eligible Dependent is now applying during an Open Enrollment period; or
      c) The coverage was ended as a result of loss of eligibility for the coverage. Such circumstances could include legal separation, divorce, death, loss of employment, or loss of coverage due to a reduction in number of employment hours or termination of the other health plan.

B) If a Late Enrollee does not enroll within thirty (30) days of a Status Change, the Late Enrollee must wait until the next Open Enrollment period to enroll.

C) The term Late Enrollee also does not include an Eligible Employee, the Eligible Employee's spouse, or a minor Dependent child where:
   (1) A court has ordered that health insurance coverage be provided for the spouse, minor child, or eligible Dependent child or an Eligible Employee.
   (2) The request for enrollment is made no more that thirty (30) days after the issuance of the court order.

2.2.5 Notification of Change in Eligibility. The Subscriber must let WHP know of any changes in name, address, marital status, and/or eligibility of any Covered family members within ten (10) days of any changes.

2.2.6 Other Rules of Enrollment.

A) If both parents are Subscribers, only one (1) parent can enroll their child as an eligible Dependent.

B) A person who previously had coverage voided under this Agreement or another WHP plan for any of the following reasons may not enroll under this Agreement:

(1) Fraud;
(2) Misrepresentation;
(3) Misuse of ID card;
(4) Failure to pay Copayments, Coinsurance or Deductibles;
(5) Failure to make premium payment; or
(6) Prior disenrollment from WHP due to disruptive behavior toward a WHP Provider, Member or employee.

2.3 **Identification (ID) Card**. Identification Cards issued by WHP to Members pursuant to this Agreement are for identification only. Possession of a WHP ID card confers no rights to services or other benefits under this Agreement. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member for whom all required payments under this Agreement have been made. Any person receiving services or other benefits to which he is not entitled pursuant to the provisions of this Agreement will be liable for all charges for such services and benefits. All ID cards are the property of WHP and must be surrendered to WHP upon request. A Member must let WHP know immediately if his ID card is lost or stolen. A Member who allows any other person to use his ID card will be terminated pursuant to Section 9.1 of this Agreement.

A) Effective Date

(1) For enrollees whose contribution is collected biweekly through payroll deduction by the State Auditor, coverage shall commence four (4) days after the payroll deduction is issued, except that those who enroll during the Initial Open Enrollment Period will have coverage effective January 1, 2009.

(2) For enrollees whose contribution is collected through payroll deduction by a Local Unit of Government, coverage shall commence the first day of the calendar month following the first premium payment, unless the Binder establishes a different date.

(3) For enrollees whose contribution is collected through payroll deduction by a direct bill agency, coverage shall commence the first day of the calendar month following the first premium payment, unless otherwise established.

(4) Coverage will terminate on the earliest of:

a) The date the Agreement is terminated.

b) The end of the period for which premiums have been paid for the following:

1. The withdrawal of deduction authorization for employee and/or dependents coverage;
2. The date premiums are due, payable and unpaid, except as a result of clerical or inadvertent error;
3. Termination of employment;
4. The date a dependent ceases to be eligible;
5. The death of the employee.

(5) Coverage for employees enrolled during the open enrollment period will be effective January 1st of the following year.

## 3. PAYMENTS

3.1 **Premium Payment Schedule**. The premium payment schedule is listed in the Agreement for Prepaid Health Care and Administrative Services Between State of Indiana and NHP of Indiana LLC d/b/a Welborn Health Plans.

3.2 **Copayments, Coinsurance and Deductibles**. All Copayments, Coinsurance and Deductibles required in Exhibit 2 of this Agreement must be paid at the time services are received. A Member must notify the Provider that he is a Member. The Provider may collect at the time of service all applicable Copayments and may also, at its option, collect any applicable Coinsurance owed. All billings from Providers for Copayments, Coinsurance and Deductibles are due upon receipt. WHP and the Provider reserve the right to fine late charges for delinquent Copayments, Coinsurance or Deductibles. If the Copayment, Coinsurance or Deductible amount is not paid within thirty-one (31) days of billing, WHP may, at its discretion, disenroll the Member upon fifteen (15) days' prior written notice to the Employer and the Member.

3.3 **Charge for Missed Appointments**. If a Member fails to appear for a scheduled appointment for health services provided pursuant under this Agreement, WHP has the right to authorize the Provider to charge the Member an amount not to exceed the usual, customary and reasonable charges for the scheduled appointments.

3.4 **Charge for Non-Referred Care and Non-Authorized Care**. Except as otherwise provided in Section 4 of this Agreement, any health services received from a Provider that were not provided by or on the order of the Member's PCP or pursuant to an authorized Referral are not Covered under this Agreement and will be billed directly to the Member by the Provider.

3.5 **Payment for Services Rendered to Non-Members**. If any non-Member uses the ID card of a Member to fraudulently obtain health services, the Member whose ID card was used will be required to pay the usual, customary, and reasonable charges and fees for the services provided to the non-Member. The Member also will be subject to disenrollment unless WHP was notified that the Member's ID card was lost or stolen prior to the fraudulent use of the card.

3.6 **Direct Billing with an Employee/Member**. WHP may upon mutual agreement with the Employer, enter into a direct billing arrangement with an employee/Member. If so, the employee/Member must pay all required premiums on or before the first day of each month. If premiums are not paid within thirty-one (31) days of the due date, WHP may end the Member's coverage retroactively to the date the premium was due. The Member will be responsible for all fees and charges for services received during any period for which premium payment has not been received.

## 4. **COVERED SERVICES**

4.1 **General Conditions**. All Covered Services are dependent upon the timely payment of premiums. The Covered Services that WHP agrees to provide or arrange for are subject to the terms that follow. Except for life-threatening Emergencies and Out-Of-Area Urgent Conditions, services are only Covered when provided by or directed by a Member's PCP. Some services also require prior approval. Services that are not listed are not Covered.

4.1.1 Covered services may be subject to Copayments, Coinsurance, Deductibles, Out-Of-Pocket Maximums and lifetime benefit limits. Please refer to Exhibit 2 of this Agreement for applicable Member cost sharing.

4.1.2 Please read Sections 5 and 6 to see what services are limited or excluded as there may be some limits to the services listed as Covered.

4.1.3 Unless stated otherwise in this Agreement, services and supplies are Covered only if provided, ordered, prescribed or Referred in advance by the Member's PCP. Claims that are received from a Provider who is not listed as the Member's PCP on their WHP ID card and no Approved Referral is in place will be the Member's financial responsibility. This does not apply to services provided by Participating OB/GYN Physicians and Eye Care Providers that do not require a Referral.

4.2 **Covered Health Care Professional Services**.

4.2.1 Health Care Professional office visits and services for diagnosis, treatment, therapy, surgery, and consultation. These services must be performed under the guidelines of WHP's Medical Management program.

4.2.2 Inpatient and outpatient Health Care Professional services. Non-emergency Inpatient Physician services must be Precertified.

4.2.3 Preventive care services:

A) Periodic physical examinations as medically indicated by the age, sex, and medical history of the Member.

B) Routine immunizations to age eighteen (18).

C) Routine pap smears, screening mammograms, prostate screening, colonoscopy screening, lab and x-rays associated with annual physical exams.

4.2.4 Allergy injections, tests and treatment.

4.2.5 Diagnostic laboratory and x-ray services received in a Physician's office.

4.2.6 Injectables including human blood products and chemotherapy. Self-injectable medications are Covered as part of a valid Prescription Drug Rider. These products must be obtained from a Participating pharmacy.

4.2.7 Obstetrical care. Physician services for routine care before delivery, during delivery and after a baby is born only if Covered under a valid Rider and Exhibit 2 of this Agreement states that these services are covered. This includes services for an eligible, enrolled Dependent child of a Subscriber. These services do not need a Referral from a PCP

4.2.8 Newborn care for an enrolled Dependent of a Subscriber or spouse.

4.2.9 Office surgery performed in a Physician's office. This includes but is not limited to diabetic foot care and vasectomy. Selected Benign Lesions treated in a Physician's office or outpatient facility are Covered.

These include lipomas, sebaceous cysts, viral warts, mulluscum and inflamed seborrheic keratoses. The Member Copayment in Exhibit 2 applies to the Covered services for Selected Benign Lesions. This includes the professional and facility charges, if applicable.

4.3 **Educational Services/Dietician Consultations** for the management of glucose intolerance, elevated cholesterol , obesity, eating disorders and gluten intolerance.

4.4 **Medical Transportation Services** when such services are:

A) Provided in connection with Medically Necessary Emergency services; or

B) Provided with a Referral from the Member's PCP or Participating Physician and approved in advance by WHP.

4.5 **Emergencies**. In an Emergency, the Member should seek care at the nearest facility. No PCP Referral is required for Emergency services. The Member should call their PCP within forty-eight (48) hours or as soon as reasonably possible. Then the PCP can continue managing the Member's care.

4.5.1 Covered Emergency services include only supplies and services needed until the Member can, without harm or injury, receive care from or through the Member's PCP. Emergency services are Covered when:

A) The Member notifies his PCP or the PCP's designated agent before seeking treatment and receives a Referral from the PCP or his designated agent; or

B) The Emergency is of a life or limb threatening nature and the delay caused by calling the PCP would result in further threat to life or limb; or

C) A Participating Provider provided the Services; or

D) Services are provided by a Non-Participating Provider pursuant to an authorization by the Member's PCP; or

E) In the case of a life or limb-threatening Emergency if a Non-Participating Provider provided the Services.

4.5.2 Medically Necessary Emergency services provided outside the WHP Service Area.

4.5.3 A Member goes to a Hospital emergency room and is admitted directly to the Hospital as an inpatient, the emergency room Copayment is waived. The Member must contact his PCP within forty-eight (48) hours or as soon as reasonably possible. This allows the PCP to be informed of the Member's condition and the PCP can coordinate his care. (NOTE: If the Member is a minor, his parent or guardian must contact the PCP.)

4.5.4 Follow-up services are Covered only when they are provided or arranged by the Member's PCP and authorized by WHP.

4.6 **Urgent Care – In Area**. Urgent Care arising inside the WHP Service Area and all follow-up care must be provided or directed by the Member's PCP.

4.7 **Inpatient Services** in the following settings:

A) Hospital.

B) Skilled Nursing Facility, subject to the benefit limitations listed in Exhibit 2 of this Agreement.

C) Rehabilitation Facility, as subject to the benefit limitations listed in Exhibit 2 of this Agreement.

D) Obstetric services for labor, delivery and post-partum care to the Member only if Covered under a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

The services included in these settings are:

(1) Semi-Private rooms or private rooms when Medically Necessary and when consistent with written Hospital rules for isolation.

(2) General nursing care.

(3) Meals (including special diets when Medically Necessary).
(4) Operating room and related services.
(5) Intensive care unit and related services.
(6) X-ray services.
(7) Laboratory, pathology and other diagnostic tests.
(8) Drugs, medications and biologicals.
(9) Anesthesia and oxygen services.
(10) Radiation and inhalation therapy.
(11) Medical/surgical supplies.
(12) Administration of whole blood and blood products.
(13) Short-term rehabilitative services and physical therapy when provided on an inpatient basis.
(14) Medical and surgical services performed by interns and residents-in-training, as defined in section 1861(b) of Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*
(15) Special duty nursing when Medically Necessary.

4.8 **Outpatient Services** including:

4.8.1 Hospital and other facility services such as day surgery and radiation.

4.8.2 Diagnostic services including: diagnostic radiology, laboratory and pathology tests and nuclear medicine services.

4.8.3 Radiation therapy services including radioactive isotope therapy.

4.8.4 Rehabilitation therapy services including physical therapy, occupational therapy, cardiac and pulmonary rehabilitation, and speech therapy.
A) Physical therapy, occupational therapy and pulmonary rehabilitation are Covered when needed as a result of injury, trauma, cancer, stroke or surgery.
B) Cardiac rehabilitation is Covered when needed as a result of myocardial infarction, unstable angina, coronary artery bypass graft surgery (CABG) or percutaneous transluminal coronary angioplasty (PTCA).
C) Speech therapy is Covered restoration of function lost as a result of trauma, injury, cancer, stroke, or surgery. Speech therapy is not Covered for developmental delay except for Autism/Pervasive Developmental Disorder (PDD) as described in Section 4.9 of this Agreement.
D) Rehabilitation therapy services must be authorized by the Medical Director and be expected to result in marked improvement within sixty (60) days of starting therapy.
E) Rehabilitation therapy services are subject to limitations as indicated in Exhibit 2 of this Agreement.

4.8.5 Skilled Home Health services (when not Custodial in nature and subject to the rehabilitation benefit limits as defined in Exhibit 2 of this Agreement) including:
A) Nursing care given or supervised by a skilled health professional who works for a state licensed Home Health agency.
B) Physical, occupational or respiratory therapy by a qualified therapist.
C) Medical supplies and lab services.

4.8.6 Hospice care.

4.9 **Other Covered Services**.

4.9.1 Alcohol/drug detoxification services, subject to the benefit limitations as listed in Exhibit 2 of this Agreement. Services for substance abuse and chemical dependency, when required in the treatment of a mental illness, will be provided at the same benefit level as other medical or surgical conditions.

4.9.2 Autism/Pervasive Developmental Disorder (PDD). Pervasive Developmental Disorder is a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Covered services for PDD are limited to treatment prescribed by the Member's PCP in agreement with a treatment plan. Other limitations and exclusions defined in the Agreement do not apply to services associated with PDD.

4.9.3 Breast reconstruction following a mastectomy as dictated by the Women's Health and Cancer Rights Act of 1998 (please see Appendix A).

4.9.4 Breast reduction when Medically Necessary.

4.9.5 Cochlear implants when Medically Necessary.

4.9.6 Corneal transplants when Medically Necessary.

4.9.7 Dental services needed for the treatment or repair of damage because of trauma to sound natural teeth. Treatment must be performed within twelve (12) months of injury. Replacement of teeth with artificial teeth, dental prosthesis or dental implants are not Covered.

4.9.8 DME services including but not limited to crutches, glucometers, wheelchairs, apnea monitors, home uterine monitors, oxygen, and oxygen related supplies/equipment and bone growth stimulators when medically necessary.

4.9.9 First pair of frames and lenses or contact lenses following cataract surgery up to the WHP maximum approved amount.

4.9.10 Hemodialysis services.

4.9.11 Hospital care related to Dental Services, including anesthesia services, for Dependent children under the age of nineteen (19) or Dependents with a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual.

4.9.12 Medical Food formulas for the treatment of Inherited Metabolic Disease.

4.9.13 Medical supplies including but not limited to casts, splints, ostomy supplies, and lancets and test strips used with glucometers.

4.9.14 Orthotic devices including, but not limited to, back braces, ankle foot orthosis, and thoracic lumbar orthosis.

4.9.15 Out-of-Area coverage of health services is limited to Urgent and Emergent conditions except as stated in Section 4.

4.9.16 Out-of-Area coverage for lab testing, oxygen supplies, or dialysis for Members with (i) diabetes, (ii) chronic lung obstructive lung disease, or (iii) chronic renal failure, respectively, who voluntarily leave the Service Area. These services must have WHP Approval in advance. Coverage is limited to a period of not more than three (3) weeks in a calendar year. No coverage for these services will be provided for Members with such conditions who must travel outside the Service Area by reason of their occupation or employment.

4.9.17 Purchase of the initial prosthetic devices including, but not limited to, artificial limbs, external breast prosthesis [limited to two (2) per year], and eye Prosthesis.

4.9.18 Reconstructive services for injury/disease provided while a Member of WHP are Covered for one (1) year from the date of original injury/disease. For children or for breast reconstruction, the one (1) year time limit does not apply. Reconstructive services do not include penile prosthesis.

4.9.19 Repairs, maintenance or replacement of DME, Prosthetics and Orthotic devices due to growth through age 18.

4.9.20 Screening examination to determine the need for hearing correction.

4.9.21 Selected Benign Lesion services for removal if performed in a Physician's office, subject to the benefit limitations in Exhibit 2 of this Agreement:

A) Lipomas;
B) Sebaceous cysts;
C) Viral warts;
D) Molluscum;
E) Inflamed seborrheic keratosis.

4.9.22 Skin Lesion removal of the following if performed in a physician's office:

A) Nevi (moles) proven to be malignant by biopsy or on an individual with previous history of skin cancer;
B) Actinic keratosis;
C) Other malignant skin lesions.

4.9.23 Temporomandibular Joint (TMJ) syndrome coverage is limited to $1,500 per contract year and includes evaluation, radiologic studies including MRI, intraoral appliances and surgery.

4.9.24 Trimming of corns and calluses.

4.9.25 Trimming of toenails is Covered when a severe disease could cause damage to the feet. Examples include diabetes, vascular disease, peripheral neuropathy, and other severe qualifying diseases as defined by the Medical Director.

4.9.26 Voluntary family planning services, including surgical sterilization.

4.9.27 Wellness programs when provided through WHP's Welcare department. Employer may purchase programs that are not Covered at an additional fee. Covered programs are limited to:

A) Basic health fair screenings (height, weight and blood pressure).
B) Educational presentations (such as back care, women's health issues, dealing with stress, proper body mechanics).

## 5. LIMITED SERVICES

Unless stated otherwise in Exhibit 2 of this Agreement or any amendment to this Agreement, the following services are limited.

5.1 **General - Limitations**.

5.1.1 A Member who is Covered at the same time by more than one (1) WHP Agreement is entitled to the maximum limit of the WHP Agreement or valid Rider with the higher benefit.

5.2 **Limited Services**.

5.2.1 Disposable or consumable bandages and medical equipment and/or supplies (including, but not limited to, sterile disposable supplies, needles, and syringes) are excluded unless provided as a part of a skilled nursing visit. Lancets and test strips used with glucometers are Covered when received from a Participating Provider.

5.2.2 Occupational and physical therapy services are limited as shown in Exhibit 2 of this Agreement.

5.2.3 Surgical treatment of Morbid Obesity is limited to one (1) surgical procedure per Member per lifetime and must be performed by a Participating Provider and authorized in advance by WHP. Services for and related to surgical treatment of Morbid Obesity will only be Covered if the treated person is a Member and the services are Covered under a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

## 6. EXCLUDED SERVICES

Benefits and exclusions may vary by Employer. Unless stated otherwise in Exhibit 2 of this Agreement or any amendment to this Agreement, the services following are excluded.

6.1 **General - Exclusions**.

6.1.1 Services that are not listed as Covered in this Agreement are not Covered and are specifically excluded under this Agreement unless otherwise Covered by a valid Rider and Exhibit 2 of this Agreement states that this service is Covered.

6.1.2 Services that exceed the limits stated in Exhibit 2 of this Agreement (such as number of days or visits, dollars, year limits, or condition limits) are excluded.

6.1.3 Claims are not eligible for consideration if not filed within ninety (90) days after the date of service. Member is financially responsible for any non-participating Provider claims not submitted to WHP within ninety (90) days from date of service.

6.2 **Excluded Services**.

6.2.1 Abortion services except when the failure to treat will jeopardize the life of the mother.

6.2.2 Administrative charges including but not limited to preparation of insurance forms and reports.

6.2.3 Ambulance services when WHP determines that the Member could be safely moved in another way.

6.2.4 Any type of care, treatment, supplies or equipment for a work-related illness, injury, or condition.

6.2.5 Appearing and testifying in any legal proceeding.

6.2.6 Aquatherapy.

6.2.7 Autopsies and related services.

6.2.8 Bedside commodes, raised toilet seats and tub/shower chairs.

6.2.9 Breast enlargement unless as stated in Section 4.9.3.

6.2.10 Chiropractic services.

6.2.11 Community reentry programs that provide services to help a disabled individual restore the functions necessary to reenter community life.

6.2.12 Complications as a result of a non-Covered service.

6.2.13 Cosmetic services.

6.2.14 Custodial Care, Residential Care, or Long-Term Care.

6.2.15 Dental Services, including but not limited to the treatment of diseases and conditions of the teeth and gums, dental exams, dental-related use of drugs, outpatient visits, surgery, orthognathic surgery, orthodontic surgery, dental prosthesis, dental implants, replacement of teeth with artificial teeth, and removal of wisdom teeth.

6.2.16 Developmental stimulation programs.

6.2.17 Dietary formulas, Medical Food formulas and nutritional supplements, except for the treatment of Inherited Metabolic Disease.

6.2.18 Directed blood donation services for anyone other than the Member.

6.2.19 Disposable or consumable bandages and medical equipment and/or supplies (including, but not limited to, sterile disposable supplies, needles, and syringes) are excluded unless provided as a part of a skilled nursing visit. Lancets and test strips used with glucometers are Covered when received from a Participating Provider.

6.2.20 All Donor related services when the Recipient is not a Member.

6.2.21 Driving evaluations.

6.2.22 Educational and testing services.

6.2.23 Elective Medical Transportation services including, but not limited to, transportation to or from a Provider.

6.2.24 Emergency services outside the WHP Service Area for:

A) Full-term pregnancy or childbirth resulting from full-term pregnancy.

B) Health care services, the need for which could reasonably have been foreseen prior to departure from the WHP Service Area.

6.2.25 Equipment provided mainly for the convenience of the patient or his family or for an adaptation to the home environment.

6.2.26 Equipment that is provided in the absence of a medical condition.

6.2.27 Exercise equipment and exercise programs.

6.2.28 Experimental/Investigative services and/or devices. A treatment, procedure, drug or device is considered experimental/investigational if it is currently the subject of a Phase I, Phase II or Phase III trial at any healthcare institution within the U.S. Furthermore, in order to be considered eligible for coverage, a treatment, procedure, drug or device must be endorsed by an authoritative statement from a specialty society, the National Institute of Health, the Centers for Disease Control and Prevention or the Center for Medicare and Medicaid Services and supported by peer-reviewed medical literature or consensus expert opinion.

6.2.29 Genetic testing for carrier status.

6.2.30 Hair analysis unless performed for diagnosis of an underlying medical condition.

6.2.31 Health services in anticipation of or arising from a lawsuit.

6.2.32 Health services for injuries sustained while the Member is driving under the influence of alcohol or drugs.

A) Driving shall mean operation of any self-propelled motorized vehicle, watercraft or aircraft.
B) Under the influence of alcohol shall mean a documented blood or breath alcohol concentration in excess of the legal limit allowed under the laws of the state or other governmental jurisdiction in which the injury occurs.
C) Under the influence of illegal drugs shall mean a positive blood or urine test for any drug listed as a controlled substance by the United States Drug Enforcement Administration. This does not apply to a controlled substance for which the Member has a valid prescription.

6.2.33 Health services mandated by a court as a stipulation of parole, probation, sentencing or any other reason.

6.2.34 Hearing aids, dentures and devices to improve communication that do not specifically improve speech are excluded as well as the evaluation or fitting of such items.

6.2.35 Home defibrillators and portable defibrillators.

6.2.36 Home health services that do not require skilled nursing care.

6.2.37 Infertility services unless Covered by a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

6.2.38 Medically unnecessary services according to generally accepted standards of medical practice including but not limited to:
A) HCG injections unless Covered by a valid Rider and Exhibit 2 of this Agreement states that these injections are Covered;
B) Behavioral training;
C) Sex change procedures;
D) Prayer or spiritual healing.

6.2.39 Mental health, chemical and/or alcohol dependency, and eating disorder services delivered at a Residential Treatment Facility.

6.2.40 Military service disability or injury for which the Member is entitled to be treated in a government facility.

6.2.41 Non-Participating Provider services.

6.2.42 Non-surgical treatment for obesity services, including but not limited to:
A) Participation in a diet program;
B) Participation in an exercise program;
C) Pharmacologic treatments, such as Xenical®.

6.2.43 Oral surgery services unless provided for under Section 4.9 or Exhibit 2 of this Agreement states that these services are Covered.

6.2.44 Organ and tissue transplants unless Covered by a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

6.2.45 Orthopedic or custom shoes unless attached to a brace or for diabetic foot deformity.

6.2.46 Penile implants, including services related to insertion, repair or replacement.

6.2.47 Personal and comfort items.

6.2.48 Prescription drugs except:
- A) When provided while the Member is an inpatient; and/or
- B) Provided for by a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

6.2.49 Private duty nursing.

6.2.50 Rehabilitative services for drug or alcohol abuse except detoxification services, or when required in the treatment of a mental illness, or Covered by a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

6.2.51 Repairs, maintenance or replacement of DME, Prosthetics and Orthotic devices, except for changes due to growth and/or if the damage to the piece of equipment is due to normal wear and tear and exceeds three (3) years beyond initial issue date.

6.2.52 Reversal of voluntary sterilization.

6.2.53 Self-help, convenience and/or environmental devices that are not primarily medical in nature or supplies which are common household items including but not limited to hot tubs, vacuum cleaners, humidifiers, folding beds, myoelectric prosthetic devices, blood pressure cuffs (unless used for home dialysis) or lift chairs.

6.2.54 Services performed by a midwife.

6.2.55 Services required for travel, school, employment, licenses, adoption, custody, life or disability insurance, and legal purposes including, but not limited to, exams, immunizations, medications, x-rays and lab tests.

6.2.56 Services to improve athletic performance, or accelerate the return to prior levels of performance to compete in organized sporting activities are excluded. This shall include, but not be limited to, programs, therapies, or custom/non-custom braces. These excluded services shall be considered services for personal and/or convenience purposes.

6.2.57 Skin Lesion removal, unless specifically provided for in Section 4.9, is excluded. Lesions include, but are not limited to:
- A) Moles;
- B) Seborrheic Keratosis;
- C) Skin tags;
- D) Keloid Scars;
- E) Scar revision;
- F) Tatoo Removal;
- G) Vitiligo (including PUVA treatment and medications);
- H) Hemangiomas, Angiomas, Telangiectasias;
- I) Xanthelasm;
- J) Lichenform lesions;
- K) Port-wine stains;
- L) Spider veins;
- M) Other lesions of the skin.

6.2.58 Surgery to remove excess tissue/skin due to weight loss.

6.2.59 Transportation to or from a Provider's office by any means including but not limited to ambulance or wheelchair transport.

6.2.60 Travel expenses related to services received under this Agreement, except for those services Covered by a valid Transplant Rider, if applicable.

6.2.61 Treatment for hair loss or baldness.

6.2.62 Treatment for port-wine stains.

6.2.63 Vagal stimulator implant for depression and related services.

6.2.64 Vision services, refractive surgery, eye refractions, eye exercises; eyeglasses or contact lenses (except the first pair of eyeglasses or contact lenses following cataract surgery. Please refer to Section 4.9); other eye appliances; or low vision aids and the replacement or fitting of such items are excluded unless Covered by a valid Rider and Exhibit 2 of this Agreement states that these services are Covered.

6.2.65 Vocational rehabilitation that is the process used by individuals with disabilities to obtain or regain skills necessary to pursue a trade or career.

6.2.66 Wellness programs not specifically stated as Covered in Section 4.9.

## 7. MEDICAL MANAGEMENT

7.1 **General**. In order to be Covered under this Agreement and any applicable Riders, all health services and items must be provided directly by the Member's PCP, as Emergency care, or through an approved Referral.

The WHP Utilization Management Program (UMP) establishes the procedures for obtaining a Referral for health care services and items. Emergency services may be provided without a Referral. Emergency admissions will be subject to review and possible post-service denial of coverage. The UMP specifies procedures for obtaining approval of health care services. This includes procedures relating to: Referrals, Precertification, Concurrent Review, Discharge Planning and Case Management. It is the responsibility of the PCP seeking the Referral to follow the procedures of the UMP. Failure to follow UMP procedures may result in WHP's denial of coverage for a health service or item. The procedures outlined in this Agreement are for general information purposes. The PCP should contact WHP for specific information and requirements.

The Medical Director may give his authority to approve a request for coverage to the Health Services Department (HSD) of WHP. A Referral will be approved only when the health service or item requested is determined to be Medically Necessary and signifies Appropriate Care. An Approved Referral will be confirmed verbally or by issuing a number or letter to the requesting PCP.

If the Medical Director decides that the Referral is not Medically Necessary or not Appropriate Care, the request will be denied. This denial is for benefit payment purposes. Only the Medical Director may deny a request. The HSD will notify the requesting PCP and the Member of the denial in writing or electronically. The PCP or Member may appeal the denial. The procedure for Appeal is in Section 14.

An Approved Referral only shows that the HSD has found the requested health service or item is Medically Necessary and signifies Appropriate Care. An Approval does not guarantee that WHP will Cover the requested health service or item because of other provisions in this Agreement. Exhibits, Eligibility, Exclusions and Limitations, Coordination of Benefits, the Benefit Summary and any applicable Riders also control whether a requested health service or item will be Covered. Approved Referrals are valid for the time stated on the Approved Referral, until the end of the contract year or loss of eligibility, whichever occurs first, and are subject to benefit limits as stated in Exhibit 2 of this Agreement.

7.2 **Precertification** is the process that determines whether a health service or item requested by the PCP is Medically Necessary and signifies Appropriate Care. The PCP should submit the request for decision at least seven (7) days prior to the anticipated date of service. A decision on routine requests will be within two (2) days of receipt of all necessary clinical information. Urgent and emergency requests will be acted upon within one (1) day of receipt of all necessary clinical information.

7.3 **Concurrent Review** is the screening process used by the HSD to assess the need for inpatient admission or continued inpatient care. Inpatient care is defined as an admission to a Hospital, Skilled Nursing Facility, or Rehabilitation Facility. The HSD will review all admissions within one (1) business day of notification. HSD will report its decision within one (1) business day.

7.4 **Discharge Planning** consists of processes initiated by the HSD to identify possible post-Hospital home care needs. This may occur at any time from the Referral approval to the Concurrent Review process.

7.5 **Case Management** is a program designed to assist and coordinate care of patients with catastrophic illnesses or injuries. The goal is to enhance the Member's quality of life and promote cost effective use of his medical benefits. The program informs Members and Physicians of the Member's benefits and possible treatment options. The HSD also arranges and coordinates needed services fostering a Member's independence.

7.6 **Claims and Appeal Process**. If a Precertification request is denied, the PCP, Member or his representative, may seek review of the request pursuant to the procedures described in Section 14 of this Agreement.

## 8. GENERAL PROVISIONS

8.1 **Gender**. The use of the masculine gender in this Agreement is for the convenience of the parties and, where necessary for comprehension, may be replaced by the feminine article.

8.2 **Headings and Titles**. The headings and titles in this Agreement are for convenience of reference only and shall not be interpreted to define or limit any of the terms herein or affect the meanings or interpretations of this Agreement.

8.3 **Parts Not Valid**. If any part of this Agreement, Exhibit 2, or valid Riders attached to this Agreement cannot be enforced, then the rest shall still be in effect unless the obligations of the parties are materially changed.

8.4 **Restrictions on Changes.** Only an officer of WHP may:

A) Change this Agreement.
B) Waive any provisions of this Agreement.
C) Extend the time for making payments.
D) Waive any of WHP's rights or requirements.

No change in this Agreement will be valid unless it is supported by an endorsement or amendment signed by an officer of WHP and specifically agreed to in writing by the Employer.

8.5 **No Assignment**. A Member or Employer may not assign or transfer any benefits or the right to receive benefits under this Agreement.

8.6 **No Waivers**. If WHP fails to have a Member follow the terms or conditions of the Agreement, it does not mean that the Member will not have to comply in the future. WHP is not bound by any coverage that was given in error at a prior time.

8.7 **Delay of Service.** WHP is not responsible for delays in providing services caused by events that are beyond WHP's control, such as, war, riot, terrorist activities, weather, ruined facilities, disabled Providers, major disasters or epidemics.

8.8 **Administration of Agreement**. WHP may adopt such policies, procedures, rules, regulations, and interpretations as it deems necessary to promote orderly and efficient administration of this Agreement and the benefits hereunder. Adoption of such policies, procedures, rules, regulations, and interpretations are part of the routine administration of health services and will not require consents from the Members. .

8.9 **Claims Processing.** To process claims, WHP uses the processing standards approved by the American Medical Association, including but not limited to CPT coding, HCPCS and Hospital revenue codes.

8.10 **Payment of Claims**. The Member must provide to WHP any information reasonably requested by WHP, and cooperate with WHP in the investigation of the Member's claim(s). Failure of a Member to cooperate in the investigation of a claim will lead to delay or denial of such claim(s). WHP shall retain the right to deny any claim not resolved (regardless of cause) within one year from date of service. Claim will become Member's responsibility.

8.11 **Relationships Among Parties Affected by this Agreement**.

8.11.1 <u>WHP and the Members</u>.

A) WHP and the Members are independent parties to each other and will not be considered agents, representatives, or employees of each other for any purpose whatsoever.

B) By receiving benefits under this Agreement, the Member accepts this Agreement. This means that all terms and rules of this Agreement are binding on the Member. The Member agrees to observe and obey all the rules of WHP as they are written in this agreement and all other WHP-initiated communications.

8.11.2 Participating Providers. WHP has created a network of Participating Providers. The relationship between WHP and the Participating Providers is a contractual relationship between independent contractors. Participating Providers have complete control over the manner in which they provide services, the time that services are performed, and the method(s) used to perform the services. No Participating Provider is an employee of WHP nor is WHP an employee or agent of any Participating Provider. Participating Providers will maintain the Provider-patient relationship without intervention from WHP. Participating Providers will be solely responsible for all medical advice to and treatment of Members for the performance of health services within the WHP Service Area. WHP will not be liable for the negligent or intentional/unintentional acts or omissions of Providers or their agents or employees. Nothing listed in this Agreement will be interpreted to require WHP or any Provider to recommend or carry-out any procedure or course of treatment that it deems medically unacceptable. WHP reserves the right to make changes to its network of Participating Providers. Participating Providers for WHP may change from time to time. WHP does not guarantee the length of time any Participating Provider will stay in the network.

8.12 **Medical Records and Confidentiality**. By enrolling in WHP, the Member agrees to make available to WHP, its agents and representatives, all of the Member's medical records, whether a Participating Provider or a Non-Participating Provider keeps such records. Where necessary, the Member agrees to execute any release or authorization forms necessary for release of medical records to WHP. However, the Subscriber's signature on the WHP enrollment form shall serve as proof of the Member's authorization to release medical records to WHP as permitted by law. WHP will hold confidential all information contained in Member's medical records. Member's confidential information will not be released without the Member's or his representative's authorization, except for:

A) Treatment. The provision and coordination by WHP of health care services provided by a Physician, Hospital or Health Care Professional.
B) Payment. The activities used by WHP to collect premiums and pay claims under WHP for health care services received by the Members.
C) Operations. The basic business functions necessary to operate WHP, such as quality assessment studies, case and disease management services, legal, actuarial and auditing services and for the resolution of Complaints and Grievances.
D) Other uses or disclosures required and authorized by Federal and State law.

8.13 **Privacy Notice**. WHP maintains compliance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and 164). WHP will store, transmit and communicate protected health information in a way that protects the privacy of individually identifiable health data as required under applicable Federal and State law.

The confidentiality of Member specific data shall be maintained and shall not be released to individuals or entities, unless for treatment, payment and operations as allowed by law as stated in WHP's Notice of Privacy Practices (please refer to Appendix B in this Agreement).

When an Employer or its representative seeks specific confidential information, such information will be released by WHP only after the receipt of written authorization from the Member or Dependents.

8.14 **Non-Discrimination**. No eligible Subscriber or eligible Dependent will be denied membership or benefits based on gender, race, creed, color, religion, handicap status, or national origin, or any other status protected by State or Federal law.

8.15 **Fraud and Abuse**. Fraud increases the cost of health care for everyone. If you suspect that a Physician, pharmacy or Hospital has charged you for services you did not receive, billed you twice for the same service or misrepresented any information, please do the following:

A) Call the Provider and ask for an explanation. There may be an error.

B) If the Provider does not resolve the matter, please notify WHP's Member Services department at (812) 426-6600 or (800) 521-0265 and explain the situation. For the hearing impaired, please call the toll-free Indiana Relay number at (800) 743-3333.

C) If the issue is not resolved, you may contact the National Insurance Crime Bureau at (800) 835-6422.

## 9. TERMINATION

9.1 **Termination (Ending) of Member Benefits and Services**. All rights to benefits and services end on the date of Member termination. On termination, Members will receive a Certificate of Prior Employer Health Plan Coverage. WHP membership may be ended for any of the reasons below:

A) Death of Subscriber. If the Subscriber dies, benefits and services to Dependent(s) shall end at the conclusion of the current period for which a premium has been paid. The Dependent(s) may have the right to Conversion or Continuation of Coverage as described in Section 10 of this Agreement.

B) Loss of Eligibility. If a Member is no longer eligible for coverage, all benefits and services shall end at midnight on the date of ineligibility.

C) Loss of student child eligibility. Student Child status ends in agreement with the provisions of Section 2. If benefits are provided after coverage stops, the Subscriber and the Dependent must pay back to WHP an amount equal to the claims paid by WHP for the Dependent and the costs of collection and reasonable legal fees. The Student Child may be eligible for Continuation of Coverage and Conversion rights as described in Section 10 of this Agreement.

D) Failure by Subscriber/Member to pay a required Copayment. The Member is expected to pay all Copayments, Coinsurance, Deductibles, and bills for unauthorized or non-Covered services. If the Member fails to make these payments, WHP or a Provider will notify the Member in writing of the failure. WHP will send Member a termination notice if payment is not made within thirty-one (31) days of the failure to pay notice. Coverage for the Member will end at midnight on the last day of the month in which the thirty-one (31) day period expires. A copy of the failure to pay notice will be given to the Employer at this same time.

E) Member wishes to end coverage under this Agreement notify WHP that a Member has elected to end coverage.

F) Lack of satisfactory Physician/patient relationship. If, after reasonable efforts, a Participating Provider is unable to establish or maintain a satisfactory Physician-patient relationship, WHP will send notice of termination. Coverage will end at midnight thirty-one (31) days after written notice of such termination. The ending of coverage may also occur if a Member displays any of the following behaviors toward a Provider or his staff:

(1) Abusive behavior.
(2) Threatening behavior.
(3) Disruptive behavior.
(4) The Member repeatedly refuses to accept a procedure or follow treatment recommended by a Participating Provider.
(5) The Member attempts to secure services in a manner that damages the ability of the Provider to coordinate the Member's care.
(6) The Member repeatedly makes but fails to keep appointments for health services.

G) Fraud or misrepresentation. If the Subscriber, Member, or his representative engages in fraudulent conduct relating to an application for Coverage under this Agreement, obtaining services, or filing a claim for benefits, Coverage terminates on the date of the fraudulent conduct.

H) Misuse of ID card. If a Member knowingly permits the use of his or any other Member's ID card by any other person, uses another person's ID card, or defaces the ID card in order to obtain services or a higher level of benefits, WHP may end the Member's coverage upon thirty-one (31) days written notice. The Subscriber shall be liable to WHP for all costs incurred as a result of the misuse of the ID card except when the Member is unaware of the misuse (e.g., a lost or stolen ID card).

I) Failure to cooperate with coordination of benefits or subrogation. If a Member fails to cooperate in WHP's administration of the coordination of benefits as outlined in Section 12 of this Agreement or with WHP's rights to subrogation or reimbursement under Section 11 of this Agreement, the Member's coverage may be ended. Termination may be retroactive to the service date of the claim in question.

J) The Agreement is terminated. If the Agreement is ended by WHP for any reason, the Member's coverage under this Agreement will end as of midnight on the date the Agreement is terminated.

K) The Agreement is terminated if the Subscriber or Member or his representative knowingly misrepresents himself in order to obtain medical services or Coverage under the terms of this Agreement.

9.2 **Member in the Hospital**. If this Agreement is ended by WHP and the Member is a bed patient in a Participating Hospital, the Member shall receive all of the benefits and services Covered under this Agreement for patients in the Hospital (i) only for the condition being treated and (ii) only for as long as that particular episode lasts or until one (1) of the following occurs, whichever is sooner:

A) Care in the Hospital is no longer Medically Necessary.

B) Benefits expire which shall be no more than sixty (60) days after the date this Agreement is terminated.

The continuation of coverage for inpatient Covered Services as listed above, is not required if the following occurs:

A) The Member obtains coverage from another carrier that includes inpatient coverage.

B) The Member terminates his Member coverage.

9.3 **Reinstatement**. WHP may, at its sole discretion, reinstate benefits and services for a Member terminated pursuant to any provision in this Section. To be reinstated, the Member must apply on forms specified by WHP.

## 10. CONVERSION or CONTINUATION OF COVERAGE

10.1 **COBRA**. A Subscriber and/or the Subscriber's Covered Dependent(s) who lose coverage due to a "qualifying event" may qualify for continuation of Employer coverage under COBRA. This continuation of coverage generally does not apply to employers of less than twenty (20) Eligible Employees. The Employer is responsible for distribution of any initial COBRA rights information and election forms. This explanation is a summary of a Member's continuation of coverage rights under COBRA. It is important to note that the Internal Revenue Service may change or amend COBRA rules from time-to-time. Members must contact their Employer about COBRA benefits.

A) Only qualified beneficiaries may elect continuation of coverage. For this purpose, a qualified beneficiary is a person who is Covered through WHP on the day before a qualifying event and is:
   (1) A Subscriber.
   (2) A Covered Dependent of a Subscriber (including a child born to or placed for adoption with the Subscriber while the Subscriber is Covered under COBRA continuation of coverage).

   A domestic partner and partner's Dependent are not considered qualified beneficiaries and are not eligible for COBRA coverage.

B) Qualifying events for continuation of coverage include only:
   (1) An end of employment of the Subscriber for any reason other than gross misconduct.
   (2) Reduction in the hours worked by the Subscriber that would result in a loss of coverage through WHP.
   (3) Death of the Subscriber.
   (4) Divorce or legal separation of the Subscriber from the Subscriber's spouse.
   (5) A Covered Dependent reaching the Limiting Age or becoming married.
   (6) The Subscriber becoming eligible for Medicare, making his Dependents eligible for COBRA.

C) In order to obtain COBRA coverage under this Agreement, the Employer must:
   (1) Notify all Members of their right to continuation of Employer coverage as required by Federal law.

D) Continuation of coverage under COBRA will be terminated when:
   (1) The maximum available period of continuation of coverage has been reached.
   (2) The qualified beneficiary fails to make a timely premium payment.
   (3) The qualified beneficiary becomes Covered by another Employer health plan after the date of COBRA election (unless the new plan has exclusions or limitations that apply to preexisting conditions of the qualified beneficiary.
   (4) The qualified beneficiary becomes Covered by Medicare benefits under Title XVIII of the Social Security Act (42 U.S.C. 1395-1395ggg).
   (5) The qualified beneficiary becomes entitled to Medicare (Part A or B) after the date of the COBRA election.
   (6) The Employer ceases to provide any Employer health plan to any Employee.
   (7) The qualified beneficiary ceases to be disabled according the Social Security Administration after the eleven (11) month disability extension has begun.

E) Members may elect COBRA coverage by completing an election form supplied by the Employer. This election form must be completed within sixty (60) days from the later of (i) the date the qualified beneficiary's coverage would ordinarily have terminated or (ii) the date the qualified beneficiary is notified of their right to elect the continuation of coverage. Except as otherwise specified, the election by a Subscriber or a spouse includes an election on behalf of any other qualified beneficiary who would also lose coverage under this Agreement as a result of that particular qualifying event.

F) The Employer may require the qualified beneficiary who elects continuation coverage to pay one hundred and two (102) percent of the premium. Upon election of the continuation of coverage, the qualified beneficiary will have forty-five (45) days from the date of election to pay the premiums for the period between the date the coverage would have been terminated under the Agreement and date of election. Claims during the elective period do not have to be paid until COBRA continuation coverage is elected and any required premium payment is made.

G) Disability extension of eleven (11) months is available after an eighteen (18) month qualifying event when the disability is effective, according to Social Security determination, prior to or within the first sixty (60) days of COBRA coverage. WHP must receive written notice of the Social Security determination within sixty (60) days of issue and prior to the end of the initial eighteen (18) months of COBRA coverage. This extension may not result in more than twenty-nine (29) months of total COBRA eligibility.

H) WHP is permitted to require the payment of any amount that does not exceed one hundred and fifty (150) percent of the applicable premium for any period of COBRA continuation coverage for a disabled qualified beneficiary, whether single or family coverage, if the coverage would not be required to be made available in the absence of a disability extension.

I) WHP will not impose more than one (1) rate increase during any twelve (12) month period for COBRA continuation coverage.

10.2 **Small Employer Conversion**. This Section applies to Employers with fifty (50) or less employees. Subscribers who are eligible for COBRA coverage must apply for that benefit.

A) Members are eligible for small Employer conversion if:

(1) They were continuously Covered under this Agreement for at least ninety (90) days.

(2) They request the conversion policy from WHP within thirty-one (31) days after loss of coverage.

(3) They cease to be Covered under this Agreement as a result of:

a) The end of employment of the Subscriber for any reason other than gross misconduct.

b) Reduction in the hours worked by the Subscriber that would result in a loss of coverage through the Employer.

c) Death of the Subscriber.

d) Divorce or legal separation of the Subscriber from the Subscriber's spouse.

e) A Covered Dependent reaches the limiting age or becomes married.

f) The Subscriber becomes eligible for Medicare, which allows the Covered Dependents to be eligible for small Employer conversion privileges.

B) The Subscriber will not be required to furnish evidence of insurability. This conversion will be without regard to health status or requirements for health services. Conversion is not available if the loss of coverage is the result of the termination of this Agreement.

C) If a Member eligible for conversion under this Section elects to exercise his conversion rights, such conversion shall be effective retroactive to the date coverage was terminated, subject to the payment of any applicable enrollment fees or premiums due for the thirty-one (31) day notice period.

## 11. SUBROGATION AND REIMBURSEMENT

11.1 **General**. If a Member or Dependent's injury or illness is caused by the acts or omissions of another party and WHP has paid expenses for such injury or illness, WHP will have the right to be reimbursed if the Member receives any payment from the other party. WHP is subrogated to all of the Member's rights against any party legally liable to pay for the Member's injury or illness. This right includes but is not limited to liability insurers of the other person and insurers covering the Member through: uninsured automobile coverage, under-insured automobile coverage, medical pay coverage under homeowner's insurance and automobile insurance policies, medical benefits coverage of an Employer, Employer-type and individual "no-fault" and traditional automobile "fault" agreements, and workers compensation recoveries. WHP may declare this right independently of the Member.

11.2 **Expenses**. When used in this section the term Expenses means the costs of all medical, surgical and hospital care furnished to the Member and provided, arranged or paid by WHP, figured on the basis of the usual, customary and reasonable fees charged by health care providers of such services. When medical expenses acquired by WHP have been subject to contractual discounts or capitation agreements, WHP shall be entitled to reimbursement based on the usual and customary fees charged by health care providers of such services, without regard to contractual discounts or capitation agreements.

11.3 **Cooperation**. The Member or anyone acting legally on his behalf must:

A) Fully cooperate with WHP in order to protect WHP's subrogation rights.
B) Give notice of WHP's claim to third parties and their insurers who may be legally responsible.
C) Provide WHP with relevant information, sign, and deliver such documents as WHP reasonably requests to secure WHP's subrogation claims.
D) Obtain WHP's consent before releasing any party from liability for medical expenses or services paid or provided.

If the Member enters into litigation or settlement negotiations regarding the obligations of other parties, the Member must not prejudice, in any way, WHP's subrogation rights.

11.4 **Reimbursement of WHP**.

11.4.1 When Member receives payment from a third party as described in Section 12.1, Member agrees to hold those funds received in trust for WHP. The Member will pay WHP from any funds received from another party by settlement, judgment, or otherwise, up to the amount of benefits provided by WHP in connection with the loss. Where there is a judgment in favor of the Member and the amount of the recovery is reduced due to fault on the part of the Member, there will be a pro-rata reduction in the amount WHP is to be paid. In such event, the amount WHP is to be paid will equal:

A) The total benefits provided by WHP for the loss.
B) The total benefits provided by WHP for the loss multiplied by the percent that the Member's recovery was reduced due to the Member's fault.

11.4.2 WHP shall have a lien on all funds the Member receives in connection with the loss. This will be in the amount of the benefits given by WHP to the Member.

11.4.3 WHP may give notice of its lien to any person or organization that is legally responsible for the loss and/or any person or organization that may be required to make payment to or for the Member in connection with the loss.

11.4.4 WHP may sue a third-party on behalf of the Member.

## 12. COORDINATION OF BENEFITS

12.1 **General**. Coordination of benefits (COB) applies when the Member also has health care coverage from Another Plan (defined in Section 12.2). Members should refer first to the rules for order of benefits of the other plan to learn if WHP's benefits are determined before or after those of the other plan. Under the order of benefit rules, WHP benefits are not reduced when WHP determines its benefits before the other plan. WHP benefits may be reduced when, under the order of benefit rules, the other plan determines its benefits first.

12.2 **Definition of Another Plan**. "Another Plan" means any of those on the list below that provide benefits or services for medical, pharmacy, or dental care treatment:

A) Employer insurance or employer coverage, whether insured or self-insured/self-funded. This includes prepayment, employer practice or individual practice coverage, and coverage other than school accident-type coverage.

B) Coverage under a government plan or coverage required or provided by law. This does not include a State Medicaid plan or any governmental plan that, by law, provides benefits in excess of any private or non-governmental insurance plan.

C) The medical benefits coverage in group, group-type and individual automobile fault and "no-fault" agreements, and premises medical expense coverage.

Each agreement or other arrangement for coverage under item (a) or (b) above is "Another Plan." If an arrangement has two (2) parts and COB rules apply only to one (1) of the two (2) parts, each of the parts is Another Plan.

12.3 **Primary or Secondary**. The order of benefit determination rules state if WHP is primary or secondary.

12.3.1 When WHP is primary, benefits are determined before those of Another Plan. The benefits of the other plan are not considered.

12.3.2 When WHP is secondary, the benefits may be reduced. WHP may recover from the primary plan, a reasonable cash value for the services provided by WHP.

When more than two (2) plans cover the Member, WHP may be primary as to one (1) or more other plans, and may be secondary as to one (1) or more of the other plans.

12.4 **Eligible Charges**. "Eligible Charges" apply when the cost of the item is Covered at least in part by one (1) or more of the plans that cover the Member. Notwithstanding the foregoing, in a coordination of benefits situation where WHP is the secondary plan, Eligible Charges will not include charges or expenses for health care services which are not Covered Services under this Agreement.

12.4.1 WHP will not cover any charges in excess of what an HMO or network Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network Provider, WHP will not consider as an allowable charge any charge that would have been Covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

12.5 **Cash Value of Services**. When a plan provides benefits as services, the fair cash value of each service given will be seen as both an Eligible Charge and a benefit paid or payment made.

12.5.1 A secondary plan that provides benefits as services may recover the fair cash value of services from the primary plan to the extent that benefits for the services are Covered by the primary plan and were not already paid or provided by the primary plan. Nothing in this Section shall be interpreted to have WHP

pay the Member in cash for the value of services provided by Another Plan that provides benefits as services.

12.6 **Claim Determination Period**. The "claim determination period" is twelve (12) months from the date of service. However, it does not include a part of a year when a person does not have coverage under WHP.

12.7 **Order of Benefit Determination Rules**.

12.7.1 General. When there is a claim under both WHP and Another Plan, WHP is secondary. Its benefits are decided after those of the other plan. The other plan may have rules that require that WHP coordinate its benefits first. In this case, it will be done in that order.

12.7.2 Rules. WHP decides the order of benefits using the first of the following rules to apply:

A) Subscriber. The plan that covers the person as a Subscriber (that is, other than as a Dependent) is determined before those of the plan that covers the person as a Dependent. If the person is a Medicare beneficiary, under Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) Secondary to the plan covering the person as a Dependent.
(2) Primary to the plan covering the person (e.g., a retired employee).

Subsequently, the order of benefits is reversed so that the plan covering the person, as a Dependent is secondary and the other plan is primary.

B) Dependent child of parents not separated or divorced. When WHP and Another Plan cover the same child as a Dependent of different persons ("Parents") who are (i) married, not separated (whether or not they have ever been married) or (ii) divorced; or if a court decree gives joint custody without specifications as to which Parent has the responsibility to provide health care coverage:

(1) The plan of the Parent whose birthday falls earlier in a year is determined before those of the plan of the Parent whose birthday falls later in that year.
(2) If both Parents have the same birthday, the benefits of WHP that Covered the Parent longer are determined before those that Covered the Parent for a shorter time.
(3) If the other plan does not have the rule described in item (ii), but instead has a rule based upon the sex of the Parent, and if, as a result, WHP does not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

C) Dependent child of separated or divorced parents. If two (2) or more plans Cover a Dependent child of divorced or separated Parents, benefits for the child are made in this order:

(1) First, the Parent with custody of the child.
(2) The current spouse of the Parent with custody of the child.
(3) The Parent who does not have custody of the child (the other parent shall be secondary).
(4) The current spouse of the Parent without custody.
(5) If the terms of a court decree state that one (1) of the separated or divorced Parents must take care of the health care coverage or medical expenses of the child, and that Parent has actual knowledge of those terms, the benefits of that plan are primary. This does not apply with respect to any claim determination period or contract year in which any benefits are paid or given before the entity has that actual knowledge.

D) Active versus inactive employees. The plan that covers a person as an employee who is neither laid-off nor retired (or is that employee's Dependent) are determined before a plan that covers that person as a laid-off or retired employee or that employee's Dependent (this does not apply if the other plan does not have this rule, and if, as a result, WHP does not agree on the order of benefits).

E) Length of time Covered. If the rules above do not decide the order of benefits, they shall be as follows:

(1) The plan that has Covered the Subscriber for the longest time is used before the benefits of the plan that Covered the person for the shorter time.
(2) Two (2) consecutive plans are treated as one (1) plan if the person who makes the claim was eligible under the second plan within twenty-four (24) hours after the termination of the first plan.
(3) The start of a new plan does not include a change in the amount or scope of a plan's benefits, a change in who provides plan benefits. It does not include a change from one (1) type of plan to another (such as from employer to individual coverage).

12.8 **WHP's Right to Receive and Release Information**. Certain information is needed to apply COB rules. WHP shall decide that information it needs from Members. WHP may obtain the information it needs or may release it to any other insurance carrier for COB purposes. Each person claiming benefits under this Agreement must provide WHP with any facts it needs to apply the rules and determine benefits.

12.9 **Facility of Payment**. When Another Plan pays a claim that should have been paid by WHP, WHP may pay that amount to the organization that made the payment. The amount may be treated as if it were a benefit paid by WHP. WHP will not have to pay that amount again.

12.10 **WHP's Right to Recovery**. If the amount paid by WHP exceeds what should have been paid under this COB provision, it may recover the excess money from:
A) The person to whom it was paid.
B) The insurer.
C) Other organization(s).

12.11 **WHP Makes Whole When Secondary**. WHP conducts COB on a "make whole" basis. This means that when WHP is secondary, it determines what it would have paid if it had been primary. It pays up to that amount toward the balance due after the primary plan is paid. This COB avoids double coverage. At times, this decreases the benefits available under this Agreement. When WHP benefits are reduced as stated above, each benefit is reduced in proportion. It is then charged against any benefit limit of WHP that applies.

12.12 **Excess Coverage**. Services, supplies or other care for injury or sickness for which there is non-group insurance (except individual health insurance policies) providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to this Agreement. If benefits subject to this provision are paid, WHP shall exercise its rights of subrogation or reimbursement as provided in Section 12.

## 13. WORKER'S COMPENSATION AND EMPLOYER LIABILITY LAWS

WHP provides benefits for care, treatment, supplies, and equipment for an illness, injury, or condition that is job-related, only if the Member is not required to be enrolled in Indiana's Worker's Compensation (or a similar state or federal program), and provided such care, treatment, supplies and equipment is or are otherwise Covered under this Agreement. If the Member is covered by Worker's Compensation, and the Member files a claim with WHP that WHP determines is for a work-related illness, injury or condition, the claim will be denied by WHP and the Member is required to file a claim with Worker's Compensation. If Worker's Compensation denies the claim as not being work-related, WHP will pay benefits under this Agreement, if benefits would otherwise be Covered under this Agreement. If WHP, in its sole judgment determines, following the initial denial of the claim by Worker's Compensation, that notwithstanding the denial, the claim is work-related, the Member is required to appeal the initial denial of the claim by Worker's Compensation. If Worker's Compensation pays the claim upon appeal, WHP has the right to reimbursement for the payments WHP made.

It is the Member's responsibility to file claims, fill out forms and provide all necessary information and cooperation required to secure Worker's Compensation benefits. It is the Member's responsibility to file an appeal of the initial Worker's Compensation. WHP benefits will not be paid if the Member is required to be covered by Worker's Compensation but is not, chooses not to file a claim with Worker's Compensation or fails to appeal an initial denial by Worker's Compensation. If WHP has paid a claim that in WHP's sole discretion is for a work-related illness, injury, or condition, and the Member does not file a claim with Worker's Compensation or appeal an initial denial by Worker's Compensation, the Member will be liable to WHP for the payments made by WHP towards the claim. If a Member receives an award from Worker's Compensation or agrees to settle a claim for permanent total or partial disability for a claim that can be settled under Worker's Compensation, the Member is responsible to pay for future medical and diagnostic services and medical equipment for or relating to the injury or condition that caused the disability.

## 14. CLAIM, APPEAL AND GRIEVANCE PROCEDURES

14.1 **What is a Claim?** A claim may be made by the Member, the Member's PCP, legal guardian or legal representative, or by someone appointed by the Member to act on the Member's behalf. A claim must be submitted to WHP in writing, and there is a formal procedure that a Member or his representative must follow to make a claim. A claim may either be a pre-service or a post-service claim as further described below. Under WHP, a claim is:

A) A request from a Member:
   (1) Seeking approval of a health care service or procedure that requires Precertification by WHP pursuant to Section 7.2 of this Agreement (such as a request for approval by WHP for an elective admission); or
   (2) Seeking approval for services or benefits for which a Participating Provider has declined to provide, authorize or seek Precertification;

B) A request for reimbursement or payment of health care expenses paid or owed by the Member for services or benefits not obtained from Participating Providers (such as reimbursement for out-of-town emergency room expenses); or

C) A request for reimbursement or payment of health care expenses paid or owed by the Member for services or benefits obtained from Participating Providers.

14.2 **Pre-Service Claims for Services or Benefits**. The following procedures are applicable to Pre-service Claims that are: (i) Requests for approval of a health care service or procedure that requires a Precertification request made by a WHP Provider pursuant to Section 7.2 of this Agreement; or (ii) Requests by a Member to WHP for services or benefits that a WHP Provider has declined to provide, authorize or seek Precertification. A Pre-service Claim will be resolved using the following procedures:

14.2.1 Urgent Care and Continuation of Current Treatment Claims. For Claims involving Urgent care services or benefits, WHP will notify the Member of its decision as soon as possible but not later than seventy-two (72) hours after receipt of the Claim. However, if insufficient information has been provided to WHP to determine to what extent the services or benefits are Covered by WHP, the Member will be notified no later than twenty-four (24) hours after receipt of the Claim of the specific information needed to process the Claim. The Member shall have forty-eight (48) hours to provide the missing information. If an Urgent care Claim involves a request that treatment or services be continued beyond the point of time or number of treatments that had been initially authorized, the Member will be notified of the decision within twenty-four (24) hours prior to the time the treatment or services are scheduled to end.

14.2.2 All Other Pre-Service Claims. For non-Urgent care Claims for services or benefits, WHP will notify the Member in writing of its decision no later than fifteen (15) days after the Claim is received by WHP unless an extension is necessary for reasons beyond the control of WHP. If WHP is unable to make a decision within the initial fifteen (15) day period, WHP will notify the Member in writing before the end of the fifteen (15) days of the circumstances requiring the extension and date by which WHP expects to make a decision which will be no later than an additional fifteen (15) days. If the reason for the extension is the failure of the Member to submit necessary information, the Member will be notified as to what information is needed, in which case the Member will have forty-five (45) days within which to submit the necessary information.

14.3 **Post-Service Claims for Reimbursement or Payment**. An initial decision on a Claim for reimbursement or payment of health care expenses paid or owed by the Member for services or benefits obtained from a non-WHP provider will be made within thirty (30) days after the Claim is received unless this time is extended. If WHP is unable to make a decision within the initial thirty (30) day period, WHP will notify the Member in writing before the end of the thirty (30) days of the circumstances requiring the extension and date by which WHP expects to make a decision, that will be no later than an additional fifteen (15) days. If the reason for the extension is the failure of the Member to submit necessary information, the Member will be notified as to what information is

needed, in which case the Member will have forty-five (45) days within which to submit the necessary information.

14.4 **Appeal**. Claims that are not satisfactorily resolved pursuant to the procedures outlined in Section 15.2 or 15.3 above must be submitted to WHP in writing as a formal Appeal within one hundred and eighty (180) days after the Member receives a determination pursuant to the procedures outlined in Sections 14.2 and 14.3 above. WHP will acknowledge the filing of a formal Appeal within three (3) business days by notifying the Member in writing.

14.4.1 Consideration on an Appeal. On an Appeal, the WHP Appeals Committee will give no weight to the initial decision that is being appealed. The Appeal will not be decided by the person who made the initial decision nor someone working under that person. In an Appeal involving medical judgment, the WHP Appeals Committee will consult with a Health Care Professional who has appropriate training and experience involving the matter being appealed and who was not involved in the initial decision (or works under such a person). All medical experts who were consulted for the initial decision will be identified. The Member may submit written comments, documents, records and other information to be considered on an Appeal. A Member will, upon request and free of charge, be provided copies of all documents, records and other information relevant to the Claim. The WHP Appeals Committee will review all available comments, documents, records and other information regarding the Appeal and make a decision.

14.4.2 Emergency/Expedited Appeals. If the Member requests an emergency/ Expedited Appeal, all necessary information to decide the Appeal will be exchanged by telephone, fax or other expedited means of communication. The Appeals Committee will reach a decision within seventy-two (72) hours from the time the Appeal was filed. The Member will be notified verbally and in writing on the same day the decision is made. If the Member is not satisfied with the decision, the written material will inform the Member of the right to appeal to the Grievance Committee.

14.4.3 Regular Appeals. An Appeal will be resolved no later than fifteen (15) days after the Appeal is filed. The Member will be notified in writing of the decision. The written notice will include the decision reached by WHP, the basis for the decision and a statement that the Member has the right to further appeal the decision through the Grievance Procedure. Also included will be the department, address and telephone number through which the Member may contract a qualified representative to obtain more information about the decision or the right to appeal. All requests to further appeal the matter to the Grievance Procedure must be made in writing and sent to:

Welborn Health Plans
ATTN: Appeals Coordinator
101 S.E. Third STreet
Evansville, Indiana 47708

14.5 **Request for Grievance Committee Review**. If the Member is dissatisfied with WHP's Appeal decision, the Member may appeal to the Grievance Committee of WHP by notifying WHP in writing within one hundred and eighty (180) days from the date the Member is notified of the Appeal decision. A Member may designate another person to file an Appeal to the Grievance Committee for the Member and represent the Member before the Grievance Committee. WHP will acknowledge the filing of an Appeal to the Grievance Committee within three (3) business days by notifying the Member in writing. Written Appeals to the Grievance Committee should be sent to:

Welborn Health Plans
ATTN: Grievance Committee
101 S.E. Third Street
Evansville, IN 47708

If an Appeal is filed by telephone, it should be submitted to Member Services at (812) 426-6600 or toll-free at (800) 521-0265.

14.5.1 A Grievance Committee will be appointed by WHP for the Appeal. The Grievance Committee will consist of the appropriate number of persons as required by State and Federal legislation, one of whom:

A) Will be knowledgeable in the medical condition, procedure or treatment at issue;

B) Will be licensed in the same profession as the Provider who proposed, delivered, or refused the health care procedure, treatment, or service in question;

C) Will not be involved in the matter giving rise to the Appeal; and

D) Does not have a direct business relationship with the Member or the Provider who proposed, delivered, or refused the health care procedure, treatment, or service involved in the Appeal. WHP's CEO and Medical Director shall be ex-officio and non-voting Grievance Committee members.

14.5.2 A meeting of the Grievance Committee at WHP's office will be scheduled and a decision made within fifteen (15) days after the Grievance Appeal is filed. The Member (or his representative) shall have the right to personally appear at the Grievance meeting where the Claim may be presented. If the Member (or his representative) is unable to appear at a Grievance hearing in person, he will be given the opportunity to communicate directly with the Grievance Committee at the Grievance Committee meeting by other appropriate means. Written notice of WHP's decision with regard to the Grievance Appeal will be sent to the Member within five (5) business days of the completion of its investigation of the Appeal. The notice will also describe the Member's right to further remedies allowed by law, including the right to an external review by an independent review organization (IRO). If the Member elects not to request an external review, the Plan's decision on the Appeal will be considered final.

14.6 **External Review of Grievances**. A Member may file a written request for an external review due to an adverse utilization review determination, an adverse determination of medical necessity, or a determination made by WHP or an agent of WHP that a proposed service by the treating Physician is Experimental/ Investigational. The request for an external review must be filed within forty-five (45) days after the Member is notified of the result of the Grievance. WHP will appoint an IRO certified by the Indiana Department of Insurance. WHP will be responsible for all costs associated with the review except for a $25 filing fee to be paid by the Member. WHP will cooperate with the IRO by promptly providing any information requested by the IRO.

A Member who requests an external review is not subject to retaliation for exercising their right to appeal. A Member may use the assistance of other individuals including physicians, attorneys, friends, and family members throughout the review process and may submit additional information relating to the proposed service throughout the review process. A Member is expected to cooperate with the IRO by providing any requested medical information or authorizing the release of necessary medical information.

Based on information gathered from the Member or the Member's designee, WHP, the treating Physician and any additional information that the organization considers necessary and appropriate, the IRO will make a decision within ten (10) business days from the date the request is filed. If the Grievance is related to an illness, a disease, a condition, an injury or disability that would seriously jeopardize the Member's life, health or ability to reach and maintain maximum function, the IRO will make a decision within seventy-two (72) hours of the time the expedited Appeal is filed. The IRO's decision is binding upon WHP.

14.7 **Lawsuits and Place of Any Lawsuit**. Any legal action filed against WHP must be filed in the State or Federal Courts located in Vanderburgh County, Indiana.

14.8 **Department of Insurance**. Parties dissatisfied with the nature of a Claim may request a review by the Indiana Department of Insurance, Consumer Services section. WHP shall forward copies of all records concerning the

disposition of the Claim to the Department of Insurance within ten (10) days of being notified by the Department. To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787
(317) 232-2395 or (800) 622-4461

## 15. AMENDMENTS TO THIS AGREEMENT

15.1 **General**. This Agreement, including all documents that are a part of this Agreement, may be amended at any time without the permission or agreement of the Subscriber or Members.

15.2 **Conformity with State and Federal Statutes**. This Agreement shall be understood, administered and enforced as an Indiana contract according to the internal laws of the State of Indiana. However, it is specifically intended that to the extent ERISA or any other Federal law preempts State law, this Agreement shall be understood, administered and enforced in agreement with such laws that preempt State law. Any provision of this Agreement that is in conflict with statutes of the State of Indiana or the Federal Government is hereby amended to conform to the minimum requirements of such statutes. The Employer will be notified of any adjustments relating to monthly premiums as a result of mandates or State or Federal law.

## 16. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. One (1) of the provisions of this act requires WHP to notify Members of their rights under this law.

**What benefits does the law guarantee?**
Under the law, health plans that provide medical and surgical benefits in connection with mastectomy must provide benefits for certain reconstructive surgery. This includes coverage for:

A) Reconstruction of the breast on which a mastectomy has been performed;
B) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
C) Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The law also states that the services will be considered "in a manner determined in consultation with the attending physician and the patient." In other words, you and your physician will determine the most appropriate treatment for your individual situation.

Coverage of these services may be subject to annual deductibles, copayment and coinsurance provisions that are consistent with those established for other benefits under this Agreement.

## 17. NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Protected Health Information ("PHI") is information, including demographic information, that may identify you and that relates to heath care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how we at Welborn Health Plans ("WHP") may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a health plan we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal and privacy practices.

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals Covered under the plan at that time.

**HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION**
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

**Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations That Do Not Require Your Prior Written Consent**
Federal law allows a health plan to use and disclose PHI for the purpose of treatment, payment and health care operations without your consent or authorization. Examples of the uses and disclosures that we are allowed to make, as a health plan, are listed below.

Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. Although, as a health plan, WHP does not provide treatment, we may provide PHI to health care providers in order to arrange treatment for you.

Payment. Payment refers to the activities of a health plan in collecting premiums and paying claims under the plan for health care services you receive. We use PHI to pay claims and we disclose PHI to companies that pay claims for WHP such as a pharmacy benefits manager or a vision plan manager. Examples of uses and disclosures under this Section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine coordination of benefits; filing and settling subrogation claims; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the plan.

Health Care Operations. Health Care Operations refers to the basic business functions necessary to operate a health plan. Examples of uses and disclosures under this Section include conducting quality assessment studies to evaluate the plan's performance or the performance of a provider or vendor; the use of PHI to provide case and disease management services; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and obtaining reinsurance; the disclosure of PHI to deal with complaints and grievances about your care; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the health plan; the disclosure of PHI to plan consultants who provide legal, actuarial and auditing services to WHP; and use of PHI in general data analysis used in the long term management and planning for WHP.

The above examples are not all of the situations when, as permitted by Federal and State law, we may use and disclose PHI for treatment, payment, and operations.

**Other Uses and Disclosures Allowed Without Your Consent**
Federal law also allows a health plan to use and disclose PHI, without your consent or authorization in the following ways:

Health Oversight. We may disclose PHI to a health oversight agency or other regulatory agency for purposes authorized by law such as audits, investigations, and inspections.

Legal Proceedings. We may disclose PHI in the course of any judicial or administrative proceeding in response to (i) an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (ii) in response to a subpoena, discovery request or other lawful process (excluding mental health records that, in Indiana, can only be released upon a court order) but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Military Activity and National Security. We may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities and for Veterans Affairs benefits eligibility. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Workers' Compensation. We may release PHI about you for programs that provide benefits for work-related injuries or illness.

When Required by Law: We may disclose your PHI as otherwise required by law, provided that the disclosure and use complies with and is limited to the relevant requirements of such law.

To the Plan Sponsor: We may disclose your PHI to the Plan Sponsor to conduct plan administration functions only if the Plan Sponsor has adopted certain safeguards to prevent the use of the PHI for employment-related decisions or in connection with any of its other benefit plans.

The examples of permitted disclosures listed above are not provided as an all inclusive list of the ways in which PHI may be disclosed. They are provided to describe in general the types of uses and disclosures that may be made.

**All Other Uses and Disclosures Require Your Prior Written Authorization**
In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we have not taken any action relying on the authorization).

At WHP, we are committed to maintaining the confidentiality of your personal and sensitive information. You and your family trust us to collect and maintain the information necessary to administer your benefit plan in a way that protects your privacy. That is why we have policies and processes in place to protect the security and confidentiality of your personal information.

**HOW WE PROTECT CONFIDENTIAL INFORMATION**
WHP is required by law to keep our members' personal information confidential. Here are things we do to make sure your personal information is protected:

- Whenever possible, we provide information that does not identify any individual. If we do need to share individually identifiable information, we have policies that protect confidentiality.
- We require a written agreement from companies and organizations who receive confidential information from us. They agree that they will use any individually identifiable information only to administer your benefits plan in accordance with applicable laws.

- Sometimes we require a member's written authorization before we disclose confidential information. For example, a request from a research organization or from a member's attorney would require an authorization signed by the member. Requests for confidential information for a minor or for an adult who is unable to exercise rational judgment or give informed consent require an authorization from the member's parent, legal guardian, or health care representative.
- We educate our organization on how to protect the confidentiality and security of your personal information. Our employees may not disclose information to other employees except when it is needed to conduct WHP business.
- Access to our facility is limited to authorized personnel.
- We have policies and procedures for accessing, labeling and storing confidential records.

**YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

- You have a right to request restrictions on uses and disclosures of your personal information with respect to treatment, payment and health care operations. WHP will consider your request, but we are not legally required to accept it. You may not limit the uses and disclosures that we are legally required to make.
- You have a right to request in writing that we send information to you at an alternate address if you include a statement in your request that the disclosure of all or part of the information to which the request pertains could endanger you.
- You have the right to inspect and copy your PHI for as long as WHP maintains the PHI. Federal law does prohibit you from having access to the following records: psychotherapy notes; information complied in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed.
- WHP strives to make sure that information is accurate and complete. You have the right to request that your PHI be amended for as long as the plan maintains the PHI. The plan may deny your request for amendment if it determines that the PHI was not created by the plan, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the plan has a right to include a rebuttal to your statement, a copy of which will be provided to you.
- You have a right to obtain an accounting of instances in which we have disclosed your personal information after the official compliance date of April 14, 2003. An accounting will be provided within sixty (60) days of receipt of the request and will not include uses or disclosures that we are allowed to make for treatment, payment or health plan operations.

**HOW WE LET MEMBERS KNOW ABOUT OUR PRIVACY PRACTICES**

WHP will provide all current subscribers with a copy of this Notice of Privacy Practices. New subscribers will receive this notice with their plan benefit materials. You can also view this notice on our Web site at www.welbornhealthplans.com or you can request a copy from our Compliance Department by calling (812) 426-6600 or (800) 521-0265, and choose option #7. For the hearing impaired, call the toll-free Indiana Relay number at (800) 743-3333.

**COMPLAINTS**

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your personal information, you may file a complaint by calling our Privacy Officer at (812) 426-6600 or (800) 521-0265, and choose option #7. For the hearing impaired, call the toll-free Indiana Relay number at (800) 743-3333. You may also call WHP for information on how to file a complaint with the Secretary of the Department of Health and Human Services. WHP will take no retaliatory action against you if you file a complaint about our privacy practices.

This notice became effective April 14, 2003.

## RIDERS: The following Riders are included in your particular benefits package.

**PRESCRIPTION DRUG BENEFITS**
**RIDER 1**

It is understood and agreed that Prescription Drug services are Covered to the extent indicated in Exhibit 2 of this Agreement and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider. Member Copayments for Prescription Drugs are not applied to the Out-of-Pocket Maximum (i.e., applicable Copayments are still required after the Out-of-Pocket Maximum is satisfied).

**Definitions**.

A) Maintenance Drug: A drug meant to sustain the health of a patient over a long period of time. This can be over several months or years. Maintenance Drugs should have an established and defined dosage for this long period of time. Regular doses of a Maintenance Drug are needed to avoid the effects of a disease or illness. Drugs that meet this definition may be excluded from the maintenance list at the direction of the WHP Pharmacy and Therapeutics (P&T) Committee. A controlled drug (e.g., Ritalin®, Lortab®, Xanax®) is not a Maintenance Drug. A first time prescription is not a Maintenance Drug.

B) Selected Pharmaceutical List (SPL): The list of *Preferred drugs* that is developed by the P&T Committee. The SPL is subject to change at the direction of the P&T Committee. This Committee periodically reviews drugs, or entire classes of drugs, to determine a drug's status as preferred or non-preferred. This determination is made based on the medication's safety, effectiveness and cost. Non-preferred drugs are Covered (subject to the Limitations and Exclusions Section below), but usually require a higher Copayment.

C) Copayment Levels:

- Prescription Drugs (30 day supply)
  - OTC Select Drugs — $5
  - Generic Prescription Drugs — $10
  - Formulary Brand Name Drugs and Formulary Diabetic Supplies — $20
  - Brand Name or Generic Non-Formulary Drugs ($40 minimum, $100 maximum) — 40% of covered charges
  - Biopharmaceutical drugs/injectable drugs — 20% of covered charges
  - Diaphragms, cervical caps — 20% of covered charges

  *If the cost of the prescription is less than the copay, the employee pays only the lesser amount.
- Family Planning
  - Fertility Counseling & Testing — 20%
  - Vasectomy — 20%
  - Tubal Ligation — 20%
  - IUD — 20%

  Benefits required under IC 5-10-8, IC 27-8, IC 27-13 and 42 CFR 417.101
- Out-of-pocket maximum (in-network) — $2000/$4000 annually
- No pre-existing condition exclusions

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**Covered Medications**.

A) Eligible medications and the refills prescribed by a Participating Provider and dispensed through a Participating pharmacy.
B) Eligible medications filled by non-Participating pharmacies when prescribed for Covered Out-of-Area Emergent or Urgent Conditions.
C) Eligible medications when prescribed by non-Participating Providers and approved in advance by WHP.
D) Insulin and insulin syringes.
E) Medications requiring Precertification provided that the Member meets medical criteria for coverage of these medications. The Participating Provider will make arrangements for Precertification. The P&T Committee defines the drugs that require Precertification and the criteria under which they will be Covered. These drugs, and the criteria for coverage, are subject to change based on the P&T Committee's drug literature reviews.

**General Conditions**. All Members are eligible for Covered Prescription Drugs under this Rider provided that the Member presents his ID card at a Participating pharmacy each time a prescription needs to be filled. (Failure to present the ID card may result in a reduction of benefits.)

**Exclusions**.

A) Any chemical means of abortion drugs, such as RU486.
B) Medication for Cosmetic purposes (e.g., Propecia®).
C) Drugs prescribed by a dentist or an oral surgeon that are intended for the treatment of dental related illnesses.
D) Experimental drugs and drugs labeled "Caution - Limited by Federal Law to Investigational Use."
E) Medicines prescribed or administered for purposes other than those approved by the Federal Food and Drug Administration unless one of the following conditions is met:
   (1) The drug is recognized for treatment of the off-label indication in at least one (1) standard reference compendium.
   (2) The drug is recommended for a particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
F) Food supplements, substitutes, formulas, etc.
G) Charges exceeding generic drug costs for name brand medications when a generic equivalent is available.
H) Lost, stolen or destroyed medications.
I) OTC (over-the-counter) drugs and non-diabetic supplies, that do not require a prescription by Federal law.
J) Prescription Drugs that have an OTC equivalent available.
K) Drugs requiring Precertification if Precertification is not obtained.
L) Drug charges that exceed the cost for the same drug in conventional packaging.
M) The quantity exceeding the limited amount based on the recommendation of WHP's P&T Committee.
N) Smoking cessation medications (e.g., nicotine gum/patches), unless participating in the Finally Beat Smoking℠ program.*
O) Take Home medication from a hospital or other facility.
P) Medications and immunizations for travel.
Q) Weight-loss medications.
R) Infertility drugs unless Covered by a valid Infertility Rider.

**Limitations**.

A) Dispensing quantities for Covered Prescription Drugs are limited to the amount prescribed by the Participating Provider, not to exceed thirty (30) day supply except for selected Maintenance Drugs that may not exceed a ninety (90) day supply.

* The Finally Beat Smoking program is a registered service mark of WHP.

B) Members who are Covered at the same time by more than one (1) Agreement or Rider are entitled to the maximum limit of the Agreement or Rider with the higher benefit. WHP does not coordinate prescription drug benefits between WHP Agreements or between other agreements and/or riders.

C) WHP does not apply prescription drug charges to the medical deductible amount.

**Payment**. All Covered Prescription Drug Benefits pursuant to this Rider are subject to Copayment, Coinsurance and/ or Deductible amounts (if any) as specified in Exhibit 2 of this Agreement. If generic is available and Member or Physician requests brand, the Member pays the applicable brand Copay plus the difference in cost between the brand and generic drug, unless otherwise approved by the WHP Medical Director.

**Interpretation of this Agreement**. Except as expressly provided by this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

**ORGAN AND TISSUE TRANSPLANT SERVICES**
**RIDER 2**

It is understood and agreed that Organ and Tissue Transplant benefits are Covered at a Maximum Benefit Per Member Per Contract Year of $1,000,000 and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider, as set forth below:

**Definitions**.

A) Donor: A live or cadaveric person donating an organ for the sole purpose of reinfusing, transfusing or transplanting into a recipient.

B) Recipient: A Member who receives an organ from a Donor. In the case of an autologous bone marrow transplant, the recipient and the Donor will be the same person.

C) Allogenic Bone Marrow Transplant: An infusion of a related or unrelated Donor's peripheral stem cells, bone marrow or cord blood to re-establish hematopoietic cell function after ablative therapy.

D) Autologous Bone Marrow Transplant: An infusion of the patient's own bone marrow, peripheral stem cells or cord blood to re-establish hematopoietic call function after ablative therapy.

E) Designated Transplant Facility: A Provider who is under contract to provide transplant services to Members pursuant to this Agreement.

**Covered Services**.

A) The Recipient Member's medical, surgical and hospital services and costs associated with organ/tissue procurement required to perform any of the following approved human organ or tissue transplants:
   (1) Heart;
   (2) Liver;
   (3) Pancreas;
   (4) Lung/Heart-Lung;
   (5) Kidney;
   (6) Bone Marrow;
   (7) Kidney/Pancreas;
   (8) Intestine (Small Bowel).

B) Reasonable travel expenses, including transportation, lodging and meals for the Member and significant other as listed in Exhibit 2 of this Agreement, subject to the approval of the Medical Director and limited to a maximum expense of $10,000 per transplant.

C) Immunosuppressive/antirejection medications including but not limited to Imuran and Sandimmune, for approved transplants, subject to a Coinsurance as defined in Exhibit 2 of this Agreement.

D) Replacement transplants and services related to a repeat transplant after initial failure.

E) Health services of a Donor when the recipient of the organ/tissue is a Member.

**General Conditions**. In order to be considered for Covered Services for human organ and tissue transplants, a Member must meet the following criteria:

A) The Member's PCP and the Medical Director must have approved, in writing, the rendering of Covered organ and tissue transplant services to the Member.

B) The Member must obtain the required approval in advance of receiving any transplant-related services. Failure to obtain preauthorization for any transplant-related services will result in non-payment of these services.

C) The Member is eligible for coverage for transplant health services listed as Covered benefits of the Agreement if such transplant health services are Medically Necessary and are provided by a Designated Transplant Facility.

**Exclusions**.

A) Services unrelated to the Covered Services defined in this Rider except as specified in the Agreement, or services unrelated to the diagnosis or treatment of an illness resulting directly from such transplants;

B) Drugs determined to be Experimental/Investigational;

**Limitations**. Organ and tissue transplant services Covered and provided under this Rider may be limited per Member to a maximum benefit if specified in Exhibit 2 of this Agreement.

**Payment**. All Covered organ and tissue transplant services provided pursuant to this Rider are subject to Copayment, Coinsurance or Deductible amounts (if any) as specified in Exhibit 2 of this Agreement.

**Interpretation of this Agreement**. Except as expressly provided by this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

**MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES**
**RIDER 3**

It is understood that mental health and chemical dependency benefits are Covered at the level listed in Exhibit 2 of this Agreement and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider, as set forth below:

**Covered Services**.

A) Acute inpatient services, including:
   (1) Structured programs of medical and psychotherapeutic services delivered to a person confined to a participating hospital's acute mental health or chemical dependency unit.
   (2) Services are delivered in a group and individual format by behavioral health professional staff and under the supervision of a licensed Physician.
   (3) Crisis assessment and brief stabilization for psychiatric conditions.
   (4) Short-term establishment of rehabilitation treatment plans. Acute inpatient services do not refer to residential services or those services primarily Custodial in nature. Services must be ordered by the Member's PCP, authorized in advance, and provided by a Participating Provider.

B) Partial hospitalization or day treatment services including:
   (1) Treatment in a structured outpatient program of psychotherapeutic services for the purposes of psychiatric assessment, crisis stabilization, and short-term treatment.
   (2) Meetings occurring at least three (3) to five (5) times a week for no less than four (4) hours and no more than twelve (12) hours per day.
   (3) iii. Services are delivered in-group and individual format by behavioral health professional staff and are under the supervision of a licensed Physician.
   (4) iv. The facility where services are delivered is not a Residential Treatment Facility. v. Services must be ordered by the Member's PCP, authorized in advance, and provided by a Participating Provider.

C) Intensive outpatient programs services including:
   (1) Structured outpatient programs of psychotherapeutic services for the purposes of psychiatric assessment, crisis stabilization, and short-term treatment.
   (2) Meetings occurring at least two (2) to three (3) times per week for not less than three (3) hours and no more than six (6) hours per day.
   (3) Services are delivered in a group format by behavioral by behavioral health staff. iv. The location facility where services are delivered is not a Residential Treatment Facility.

D) Individual psychotherapy services including services provided on a one-to-one basis between the Member and a licensed Physician or appropriately licensed/certified behavioral health professional, usually occurring in an office setting.

E) Group or family psychotherapy services including services provided by a licensed Physician or appropriately licensed/certified behavioral health professional in a structured format, treatment to two (2) or more participants or family members, and usually in an office setting.

F) Services for substance abuse and chemical dependency, when required in the treatment of a mental illness, will be provided at the same benefit level as other medical or surgical conditions.

**Exclusions**.

A) Gender identity disorders including any process, service or supply required for a sex change, deviation or disorder.

B) Residential care and all associated services and/or supplies.

**Limitations**. Mental Health and Chemical Dependency services Covered and provided under this Rider may be limited per Member to a maximum benefit if specified in Exhibit 2 of this Agreement.

**Payment**. All Covered Mental Health and Chemical Dependency services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in Exhibit 2 of this Agreement.

**Interpretation of this Agreement**. Except as expressly provided above by this Rider, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

**INFERTILITY SERVICES**
**RIDER 4**

It is understood that Infertility Services benefits are Covered at the level indicated in Exhibit 2 of this Agreement and shall be defined and provided under this Agreement in accordance with the terms and conditions of this Rider and in conjunction with the Maternity Services Rider, as set forth below:

**Definitions**.

A) Infertility: Infertility services are medical/surgical services performed to investigate and treat the causes of Infertility, which include the inability to conceive (get pregnant) or cause pregnancy, maintain pregnancy until full term, or maintain or improve desired fertility.

**Covered Services**. To be Covered, all Infertility services must be requested by a PCP and approved by the Medical Director. Covered Services will only be provided for Members. Partners/spouses who are not Members are not eligible for Covered Infertility diagnostic and treatment services.

A) Diagnostic services for the Member partner(s) to establish cause or reason for infertility.
B) Pathology and laboratory services.
C) Surgical services.
D) Drugs prescribed for Covered Infertility treatment subject to a Coinsurance.

**General Conditions**. In order to be considered for Covered Services related to the evaluation and treatment of Infertility, a Member must meet the following criteria:

A) The Member must be married and the Member and the Member's spouse must have had unprotected intercourse without conception for at least one (1) year; and
B) The male partner must have had a sperm analysis performed:
   (1) If the male partner is a Member, the sperm analysis must have been performed by a Participating Provider.
   (2) If the male partner is not a Member, the sperm analysis must have been performed with the results being sent to the Member's PCP.
C) The female partner must have been unable to achieve and sustain two (2) successful pregnancies in her lifetime.

**Exclusions**.

A) Invitro fertilization.
B) Gamete or zygote intrafallopian transfer (GIFT or ZYFT).
C) Reversal of voluntary sterilization.
D) Embryo transplantation.
E) Experimental services.
F) Artificial insemination.
G) New technology not defined under the Covered Services Section of this Rider unless authorized by the Medical Director.
H) Drugs, testing, surgical procedures and services associated with Exclusions (A) through (G) above.
I) Infertility drugs unless Covered by a valid Prescription Drug Rider.

**Limitations**. Infertility services Covered under this Rider are subject to the following limitations:

A) Benefits for Covered Infertility evaluation and treatment services are not extended beyond two (2) years. These services are Covered only if the current Agreement or Rider covering Infertility is still in force and the Member is still an eligible Member.
B) All Covered Services and equipment for Infertility are subject to Coinsurance charges for the services or equipment.

C) If pregnancy is achieved, but terminated through spontaneous abortion or premature birth, Covered Infertility benefits will be extended for a one (1) year period following the fetal loss.
D) In no circumstance will services for Infertility be Covered beyond two (2) successful pregnancies resulting in live birth.
E) Services for Infertility evaluation and treatment will only be Covered so long as the treated person is a Member.

Infertility Services Covered and provided under this Rider may be limited per Member to a maximum benefit if specified in Exhibit 2 of this Agreement.

**Payment**. All Covered Infertility Services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in Exhibit 2 of this Agreement.

**Interpretation of this Agreement**. Except as expressly provided by this Rider, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

**SURGICAL TREATMENT OF MORBID OBESITY**
**RIDER 5**

It is understood and agreed that morbid obesity benefits are Covered at the level indicated in Exhibit 2 of this Agreement and shall be defined and provided under the Agreement in accordance with the terms and conditions of this Rider, as set forth below:

**Definitions.**

A) Morbid Obesity: (Ind. Code §§ 27-8-14.4 and 27-13-7-14.5):
   (1) A body mass index of at least thirty-five (35) kilograms per meter squared, with co morbidity or co-existing medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
   (2) A body mass index of at least forty (40) kilograms per meter squared without co-morbidity.

B) Non-surgical treatment of Morbid Obesity:
   (1) Medical documentation of participation and compliance with a diet program, supervised by a PCP, for at least six (6) months; and
   (2) Medical documentation of participation and compliance with an exercise program for at least eighteen (18) months supervised by a PCP; and
   (3) Documented attempt of at least six (6) months of pharmacologic, such as Xenical® treatment supervised by a PCP; and
   (4) Evaluation by a Participating mental health professional.

**Covered Services.** These services are limited to those procedures deemed most appropriate for the specific Morbid Obesity condition, as determined by the WHP Medical Director and by the Participating Provider. This includes office consultations and follow-up visits by the bariatric surgeons and consulting Providers as well as the surgery, facility fees and any other services or consultations. Complications from the surgery will also be subject to the limitations of this Rider. Obesity surgery includes but is not limited to the following procedures:

A) Gastric banding.
B) Adjustable gastric banding.
C) Gastric bypass.
D) Gastric restrictive procedure with gastric bypass and Roux-en-Y.
E) Partial gastrectomy with Roux-en-Y reconstruction.
F) Partial gastrectomy with intestinal pouch.
G) Total gastrectomy with Roux-en-Y reconstruction.

**General Conditions.** The Member's PCP and the WHP Medical Director must have approved, in writing, the request for the services for surgical treatment of Morbid Obesity.

**Exclusions.**

A) Failure to meet any above criteria for diagnosis of Morbid Obesity or non-surgical treatments.
B) Use of a Non-Participating Provider.
C) Unwillingness to comply with diet and/or other treatment recommendations.
D) Services incurred without receiving prior approval from WHP.
E) Weight-loss medications.
F) New technology not defined under the Covered Services Section of this Rider unless authorized in advance by the WHP Medical Director.
G) Removal of excess skin as a result of weight loss.

**Limitations.** Surgical treatment of Morbid Obesity is limited to one (1) surgical procedure per Member per lifetime and must be performed by a Participating Provider and authorized in advance by WHP. Services for and related to surgical treatment of Morbid Obesity will only be Covered as long as the treated person is a Member.

The Member must be at least 21 years old to have Morbid Obesity surgically treated. A Member less than 21 years of age will only be eligible for surgical treatment of Morbid Obesity if two (2) physicians licensed under Ind. Code § 25-22.5 et seq. determine the surgery is necessary to save the life of the Member or to restore the Member's ability to maintain a major life activity as defined in Ind. Code § 4-23-29-6. Each physician must document in the Member's medical record the reason for the physician's determination.

The Morbid Obesity must have persisted for at least five (5) years and non-surgical treatment that was supervised by a Physician has been unsuccessful for at least six (6) consecutive months.

**Payment.** All Covered Morbid Obesity services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in Exhibit 2 of this Agreement. The Member Coinsurance for Morbid Obesity services does not apply to the Out-of-Pocket Maximum.

**Interpretation of this Agreement**. Except as expressly provided by this Rider, or by other Riders, that shall be made part of this Agreement, the terms and conditions of the Agreement control and remain the same and are in full force and effect.

**MATERNITY SERVICES**
**RIDER 6**

It is understood and agreed that Maternity benefits are Covered at the level indicated in Exhibit 2 of this Agreement and shall be defined and provided under the Agreement in accordance with the terms and conditions of this, as set forth below:

**Definitions.**

A) Maternity Services: Obstetrical services rendered to a woman from the time the pregnancy as established by a Participating Provider until delivery or termination of pregnancy and discharge from the hospital or other facility for rehabilitation services.

**Covered Services.** Covered services includes when pregnancy is confirmed by a Participating Provider:

A) Office visits by a Participating Provider;
B) Ultrasound examinations;
C) Laboratory, pathology and other diagnostic tests;
D) X-ray services;
E) Drugs, medications and biologicals;
F) Anesthesia and oxygen services;
G) Medical and surgical supplies;
H) Administration of whole blood and blood products;
I) General inpatient nursing care;
J) Inpatient meals;
K) Operating room and related services;
L) Labor and delivery room, and related services;
M) Intensive care unit and related services;
N) Semi-Private rooms or private rooms when Medically Necessary and when consistent with written Hospital rules for isolation;
O) Short-term rehabilitative services and physical therapy when provided on an inpatient basis;
P) Rehabilitation Facility, as subject to the benefit limitations listed in Exhibit 2 of this Agreement;
Q) Medical and surgical services performed by interns and residents-in-training, as defined in Section 1861(b) of Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.;*
R) Special duty nursing when Medically Necessary;
S) Obstetric services for labor, delivery and post-partum care to the Member only. The minimum length of stay for a vaginal delivery is forty-eight (48) hours. The minimum length of stay for a cesarean section is ninety-six (96) hours. However, a shorter length of stay can be arranged if:
   (1) The Member and attending Physician agree the mother does not need further inpatient care;
   (2) In the attending Physician's opinion, the newborn meets the criteria for medical stability under the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines; and
   (3) One (1) at-home post-delivery care visit is provided.

**Exclusions.** Non-Participating Provider services unless Emergency/Urgent maternity situation.

**Limitations.** Maternity/Obstetrical Services Covered and provided under this Rider may be limited per Member to a maximum benefit as specified in Exhibit 2 of this Agreement.

**Payment.** All Covered Maternity/Obstetrical Services provided pursuant to this Rider are subject to Copayment, Coinsurance and/or Deductible amounts (if any) as specified in Exhibit 2 of this Agreement.

**Interpretation of this Agreement.** Except as expressly provided above by this Rider, or by other Riders, that shall be made part of the Agreement, the terms and conditions of the Agreement control and remain the same, are in full force and effect.